CHAPTER THIRTEEN

Gambling-Related Harms In Females: A Resource For Practitioners and People Working In the Field

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There is a well-recognised gender bias in the gambling literature, with theories and research having typically focused on males' experiences of harmful gambling (McCarthy et al., 2019). There are several reasons for this disproportionate attention given to males, including that being male has consistently been found to be a risk factor for harmful gambling and gambling-related harms (Dowling et al., 2017). This focus is therefore understandable in some sense. However, a male-based model of gambling hinders a comprehensive understanding of this "hidden addiction" and limits the applicability of existing treatments and policies to female gamblers, at a time when gambling participation rates have increased in females. This increase is attributable in part to increased access through online platforms (which entail anonymity), as well as the 'feminisation' of some forms of gambling where certain products have been made more appealing to women, and gambling is increasingly considered more acceptable as a leisure activity for women (McCarthy at al., 2019). At the same time, women often appear more vulnerable to gambling-related harms (Sharman et al., 2019), and female gamblers present a more distinct clinical and psychological profile than men (Andronicos et al., 2015).

The evidence identifies a need to focus on the unique requirements of women affected by harmful gambling and the distinct challenges they face. In this chapter, we summarise contemporary research and theories concerning gambling in women. We begin with an overview

of the prevalence of gambling among women and a gender-specific comparison of gambling patterns. We then provide a summary of the clinical profile of female gamblers and the motivations and mechanisms underpinning their gambling behaviour. Finally, we discuss the existing knowledge about policy strategies aimed at preventing women from suffering gambling-related harms and treatment interventions for females gambling problematically.

Prevalence of Female Harmful gambling

Being male is a consistent risk factor for harmful gambling in both cross-sectional and longitudinal studies (Dowling et al., 2017). Indeed, gender differences in the rate of harmful gambling across various population-based surveys is well documented in the international literature (Blanco et al., 2006; Hare, 2015; NatCen, 2020; Wardle et al, 2011). The National Epidemiological Survey of Alcoholism and Related Conditions (*n* = 43,093) in the US found the lifetime prevalence of harmful gambling to be 3.26% for women and 6.79% for men (Blanco et al., 2006). In the British Prevalence Survey in 2010 (*n* = 7,756), 1.5% of men met the diagnostic criteria for current harmful gambling versus 0.3% of women (Wardle et al., 2011), while in the Health Survey in England in 2018 (*n* = 6927), 0.7% of men met such criteria versus 0.3% of women (NatCen, 2020). In the Victorian Prevalence Study in Australia (2014; *n* = 13,554), about 1% males and 0.6% of females were experiencing current harmful gambling (Hare, 2015). As can be noticed in the above studies, the male to female prevalence ratio has consistently been approximately two to one, a finding similar to that of more recently published studies from other countries (Carneiro et al., 2020; Izutsu & Suzuki, 2021; Wejbera et al., 2021).

Males are most at risk of harmful gambling, as shown in the First Brazilian National Alcohol Survey and Related Behaviours (2005–2006; *n* = 3007), where men were 2.3 times more at risk of gambling exposure and 3.6 times more likely to experience gambling-related problems

(Carneiro et al., 2020). In the German Gutenberg Health Study (2007–2012), in a sample of 11,875 people between age 40 and 80, lifetime probable gambling disorder prevalence was 3% in men versus 1.2% in women (Wejbera, et al., 2021). The Canadian Community Health Survey (2013–2014; *n* = 38,968) determined the prevalence of harmful gambling as 1.9% among males and 0.9% among females (Izutsu & Suzuki, 2021). The above studies indicate that while most individuals gambling pathologically are male, women comprise roughly one third of this population, a significant proportion that shows women are not immune to gambling-related harms.

Women have been identified in the literature as a vulnerable group in relation to exposure to gambling and its related harms (McCarthy et al., 2019; Sharman et al., 2019). There has been an upward trend in women's gambling and harmful gambling. For example, between 2007 and 2010 female gambling increased from 65% to 71% in the UK, and from 0.2% to 0.3% in terms of pathological gambling (NatCen, 2008; Wardle et al., 2011). Data from France (Costes et al., 2011; Costes et al., 20152015) and Australia (Hare, 2015) demonstrate a similar pattern. Second, gambling rates are almost equivalent for men and women in some countries, such as the UK (NatCen, 2020, Wardle et al., 2011), New Zealand (Abbott et al., 2014a) and Canada (Kairouz et al., 2011).

The increased involvement of women in gambling has been attributed to various reasons; the 'feminisation' of certain forms of gambling; gambling being more socially acceptable and less stigmatised; advances in gambling technologies and marketing; and strategies targeting women (McCarthy et al., 2019). It has been speculated that the increased prevalence represents a cyclic resurgence rather than a new phenomenon but is likely to be linked to societal change and targeted advertising (Althaus et al., 2021). Thus, women are certainly not protected from gambling-related

harms as they represent a significant proportion of individuals gambling pathologically, with gender roles and expectations changing in an ever-evolving gambling landscape.

Furthermore, certain female groups are particularly vulnerable to gambling-related harms. For example, a study of Indigenous Australian women revealed elevated rates of gambling participation and a high prevalence of gambling problems compared to the general population (Hing et al., 2014). Similarly, the prevalence of at-risk (6.2%), problem (9.3%) and pathological gambling (19.1%) within a sample of 162 women using shelter and drop-in services in Canada was higher than in the general population (Matheson et al., 2021). Likewise, in New Zealand, gambling rates are now broadly equal between males and females in several jurisdictions, and Disordered Gambling risk rates are converging to the point where statistical differences are not evident (e.g., in the case of lifetime probable pathological gambling there is no gender difference; Abbott et al., 2014b), and around 45% of gambler clients seeking help are women—and the majority of all clients when affected others are included (Kolandai-Matchett et al., 2015). Indeed, even where gambling participation rates are not higher, there is still elevated risk of harm, especially in minority groups (e.g., Pasifika; Abbott et al., 2014b). In the only study to date to examine gambling involvement among young transgender and gender diverse people, greater involvement in most gambling behaviours and harmful gambling were identified. Notably, transgender/gender diverse people assigned male at birth were particularly at risk of gambling involvement and harmful gambling (Rider etl., 2019).

Note for health professionals/ practice:

Women cannot be assumed to be protected from gambling-related harms as they represent a significant proportion of individuals affected by problem gambling.

Patterns of Gambling Behaviour

The initial exposure to gambling and the course of a gambling career appear to differ between genders. According to some studies, men are often exposed to gambling in their late teens and/or early twenties, while women often start gambling in their mid-30s (Echeburúa et al., 2011; Granero et al., 2009). However, the age of the first gambling episode is decreasing for both males and females in younger generations (Richmond-Rakerd et al., 2013; Wardle et al., 2011). Some studies have shown that women progress more quickly than men from their initial gambling episode to the development of harmful gambling, a phenomenon that is well-known as the telescoping effect (e.g., Potenza et al., 2001). However, there are notable exceptions to the telescoping effect. For example, the First Brazilian National Alcohol Survey and Related Behaviours found that women's progression to harmful gambling takes approximately ten years, compared to only three years for men (Carneiro et al., 2021). Likewise, an Australian study did not find a telescoped disordered gambling trajectory for women compared to men (Slutske et al., 2015). This may be due to the preference for and accessibility of forms of gambling like electronic machine gambling which are often found in pubs and bars (thus more common among men than women), and is related to a shorter time to symptoms of disordered gambling (Slutske et al., 2015). Regulations in Brazil that prohibit various gambling games may have, at least partly, also contributed to this finding.

Differences in gambling format between men and women are also documented in the literature. Women seem to prefer chance-based and high-absorption forms of gambling like bingo and slot machines (Karter, 2017; Potenza et al., 2001; Stark et al., 2012), which may be attributed to a different type of motivation driving female gambling. However, men tend to engage in a greater range of gambling activities, ranging from cards and table games at casinos to sport betting

and speculative investment (Stark et al., 2012). Men's gambling is also more oriented towards skill-based and strategic games (Stark et al., 2012; Svensson & Romild, 2014) that are often more competitive and exhilarating in nature, but may not have been sufficiently feminised yet. We may therefore see similar preferences in both men and women in the future and a further rapid escalation in broader engagement with gambling products by women.

There is some evidence that the form of gambling is relevant to gambling behaviour and gambling-related harms (Latvala et al., 2019; Stark et al., 2012). The types and number of games played among men were found to mediate their higher prevalence rates of gambling and greater gambling severity (Stark et al., 2012). Types of gambling were linked to lower academic performance overall, but after controlling for sociodemographic variables this relationship was no longer significant in women, but remained for men (Latvala et al., 2019). For women, it was mainly playing several different forms of gambling that was linked to low school performance (Latvala et al., 2019).

Note for health professionals/ practice:

Given the ever changing, dynamic nature and feminisation of the gambling industry, practitioners should be vigilant for a rapid escalation in engagement in more forms of gambling in women.

Clinical Characteristics

Females gambling problematically have significantly higher rates of self-reported psychological distress and concurrent or past difficulties than both males (Andronicos et al., 2015; Getty et al., 2000; Petry et al., 2005a) and the general female population (Boughton & Falenchuk, 2007). Specifically, female gamblers report significantly greater levels of depression, maladaptive

coping, and other comorbid mental health conditions than men (Andronicos et al., 2015; Getty et al., 2000). Other studies have found childhood maltreatment to be more prevalent in female than male gamblers (Andronicos et al., 2015; Merkouris et al., 2015; Petry et al., 2005a). Likewise, females at risk of gambling-related harms have considerably elevated rates of depression and anxiety, concurrent struggles with other behaviours such as alcohol and drug use, disordered eating, overspending, criminal activity, and abuse (Boughton & Falenchuk, 2007; Merkouris et al., 2015). Notably, the above studies have taken place in clinical settings or with at-risk populations. Studies examining gender differences in gamblers' profiles using nationally representative samples present a more mixed picture (Bonnaire et al., 2016; Petry et al., 2005b; Wejbera et al., 2021). One study found the strength of associations between harmful gambling and substance abuse, major depressive episodes and generalised anxiety disorder to be stronger among women than men in the US (Petry et al., 2005b). Conversely, in a sample of Germans aged 40 to 80 years showed men with gambling problems to have significantly increased rates of imprisonment (3.5% of those with probable gambling disorder versus 0.5% of those without), mental health symptoms (16.8% versus 6.3% for depression; 10.8% versus 4.9% for anxiety), and somatic symptoms (24.6% versus 11.7%)—differences not found among women (Wejbera et al., 2021). In France, individuals gambling problematically present with increased psychological distress compared to the general population regardless of gender, and there are more females who score above the clinical cut-off for psychological distress than males, both in the harmful gambling and general population (26.8% of males gambling problematically scored above the clinical cut-off versus 7% of males not gambling problematically, and 43.4% of females gambling problematically versus 15.9% of females not gambling problematically; Bonnaire et al., 2016). Furthermore, in two large community samples (Hodgins et al., 2010; Venne et al., 2020), women with gambling problems

did not report greater maltreatment than men with gambling problems (Hodgins et al., 2010), while males gambling problematically were more likely to report unhappier childhoods (Venne et al., 2020).

Considering all findings on female gamblers' psychological profiles, including research conducted with clinical and national samples, the results appear somewhat inconsistent. When focusing on clinical samples and older research conducted with a national sample, female gamblers present with higher rates of psychological comorbidity (Andronicos et al., 2015; Getty et al.,2000; Petry et al., 2005a; 2005b). However, this is not strictly true when considering comparisons between male and female gamblers in community samples (Bonnaire et al., 2016; Hodgins et al., 2010; Venne et al., 2020; Wejbera et al., 2021). One could hypothesise that as access to gambling increases for women, female gambling profiles are changing and do not predominantly concern those with more complex clinical profiles and higher comorbidity.

There is also inconsistency between studies that compare the relationship of substance use and harmful gambling between genders in large community samples (Bonnaire et al., 2016; Desai & Potenza, 2008; Petry et al., 2005b; Pilver et al., 2013; Venne et al., 2020; Zhai et al., 2020). Earlier research has found that there are stronger associations among women between harmful gambling and various substance use disorders (Petry et al., 2005b), including nicotine dependence (Desai & Potenza, 2008). Two more recent studies also identified strong associations between nicotine dependence and harmful gambling among women (Bonnaire et al., 2016; Pilver et al., 2013). However, converse to other studies, Pilver et al. (2013) also found male gamblers more likely to develop alcohol-related disorders than women, contradicting the findings of Bonaine et al. (2016) and Venne et al. (2020). Similarly, no significant interactions between gambling and gender were found for the use of any substance among an adolescent sample, with the exception

of synthetic marijuana which females were more likely to report using in relation to gambling (Zhai et al., 2020). No other substance has consistently been associated with female harmful gambling in the literature.

Research comparing violent behaviour in gamblers has found gambling to be linked to most dimensions of violence regardless of gender, with both genders having experienced the position of perpetrator and/or victim (Roberts et al., 2018; Suomi et al., 2021; Zhai et al., 2020). However, there is some evidence to suggest that female gamblers are at increased risk of being a victim of relational violence compared to non-gambling women or male gamblers. Roberts et al. (2018) found that female gamblers were more likely to be a victim of partner-violence than the national population, a finding not replicated for men. Women with mood, anxiety, alcohol abuse or personality disorders were more likely to be abused by a partner, suggesting a relationship between mental health and physical violence in female gamblers (Roberts et al., 2018). Another study also found that female students who were gamblers were more likely to be victims of dating violence (Zhai et al., 2020).

Note for health professionals/ practice:

Practitioners should be aware of underlying comorbidities and experience of previous and on-going adversity (such as interpersonal violence) and tailor treatment on an individual person basis that takes into account personal circumstances.

Motivation

The motivation for gambling among females often appears somewhat distinct from that of males. Drawing on alcohol literature (Cooper, 1994), non-gender specific gambling research initially distinguished between three categories of gambling motives: social, enhancement, and coping (Milosevic & Ledgerwood, 2010), to which a fourth category of financial motives was

subsequently added (Dechant, 2014). Earlier research found different gambling motives between genders (Legge, 1996; Stewart & Zac, 2008), wherein women were more strongly motivated by escapism, corresponding to coping motives (Legge, 1996), and coping motives generally have been found to be more strongly linked with gambling severity in women (Stewart & Zac, 2008).

The higher rates of comorbidity in female gamblers in clinical samples (Andronicos et al., 2015; Getty et al.,2000; Petry et al., 2005a) could provide further support to the hypothesis that women engage in harmful gambling for coping purposes. A recent in-depth qualitative analysis of the motivations of female gamblers (Lelonek-Kuleta, 2021) and earlier clinical observations deriving from treatment groups with female gamblers (Karter, 2017) also place emphasis on social and coping (and not financial) motives in female gamblers. In line with the above findings, other researchers found that female gamblers are more likely to present with anxiety or depression before the onset of their gambling, and their depression and/or anxiety acted as a risk factor for harmful gambling. Their findings contrasted with those of men, for whom gambling was likely to be the first condition to evolve, preceding any secondary psychological difficulties that later develop because of their gambling (Sundqvist & Rosendahl, 2019).

The influential pathway model also expounds gamblers' motivations and identifies a useful direction for the role of gender. The model proposes three distinct subtypes of gamblers: (a) the behaviourally conditioned, driven by the effects of behavioural conditioning related to gambling and marked by an absence of marked premorbid psychopathology, (b) the emotionally vulnerable, comprising individuals with underlying vulnerabilities and premorbid psychopathology for whom gambling typically represents a coping strategy, and (c) the antisocial and impulsive risk-takers, presenting with high impulsivity, attention deficits and antisocial traits, often indicative of neurobiological or neurochemical disfunction manifesting in multiple domains. Each subtype

implies that a distinct set of motivations may underpin gambling behaviour (Blaszczynski & Nower, 2002).

In a recent study that tested the pathway model, women were more likely to classify as the emotionally vulnerable subtype and less likely to be antisocial–impulsive gamblers (Nower & Blaszczynski, 2017). Although the proportions of men and women classified in the second subtype were equal in the adolescent population, a higher proportion of males in both the first and third subtypes of individuals gambling problematically was present (Gupta et al., 2013). Thus, it could be suggested that an underlying vulnerability, for which gambling has a coping function, is a pertinent feature in female gamblers' clinical picture. This is not to underestimate the role that emotional motives play for men. In large community samples, negative coping abilities increased the odds of harmful gambling for both men and women (Afifi et al., 2010), and the emotional motivation for harmful gambling was significantly stronger among males in one study (van der Maas et al., 2019).

Note for health professionals/ practice:

Practitioners should note that women are more likely to use gambling as a means of escape and coping, which should be discussed in treatment.

Biological and Neurocognitive Mechanisms

There is preliminary evidence indicating distinct genetic, biological, and neurocognitive mechanisms underpinning gambling behaviours that are unique or more pertinent in females (e.g., Joyce et al., 2019; Joyce et al., 2021; Mallorquí-Bagué et al., 2021; Slutske et al., 2013). For example, one study concluded that genetic risk was more pronounced among females than males

(Slutske et al, 2013), with genetic differences explaining 40% to 60% of the variation in the risk of harmful gambling for women and 20% for men (Slutske et al., 2013). However, this conclusion contrasts that of a meta-analysis examining the role of genetics in harmful gambling that found stronger heritability in males (see Walters, 2001).

Research on the impact that women's menstrual cycle has on gambling has also provided contradictory evidence (Joyce et al., 2019; Joyce et al., 2021). While no association was found overall between menstrual cycle and gambling behaviour in a full systematic review (Joyce et al., 2021), an earlier empirical study did generate evidence that gambling behaviour increases during ovulation, suggesting enhanced reward sensitivity (Joyce et al., 2019). Likewise, gender differences in the neurocognitive domain of compulsivity has consistently been found to be impaired in individuals presenting with harmful gambling (Leeman & Potenza, 2012). In one study, it was concluded that women gamblers present with worse attentional set-shifting, referring to the ease with which the focus of attention is directed and switched, indicating an interaction between gender and the role of compulsivity in harmful gambling (Mallrqui-Baque et al., 2021). As research on the biological mechanisms presented in this chapter is in its infancy, further research will need to be conducted before definitive conclusions about unique mechanisms in females can be reached.

Note for health professionals/ practice:

It is useful for individuals in treatment to understand better what they are up against when they are trying to break free from gambling; hormones, genetics and neurocognitive mechanisms all come in the equation.

Policy

As already mentioned, there has been an upward trend in women's gambling and pathological gambling internationally (Costes et al., 2011; Costes et al., 2015; Hare, 2015; NatCen, 2008, 2020; Wardle et al., 2011). Such a trend has been attributed to changes in the gambling landscape and industry, including the feminisation of gambling products, gambling being more accessible, changes in technology, and marketing strategies targeting women specifically (McCarthy et al., 2019). It has been shown that certain groups of women are more vulnerable. For example, it has been shown that women aged 55 or above downplayed or ignored the risks associated with electronic gambling machines, partly because their risk perceptions were shaped by early recreational experience of gambling or because the benefits of social interaction outweighed the potential harms (McCarthy et al., 2021). Likewise, some young women aged 18 to 34 years who were exposed to gambling environments started to gamble from an early age; with increased accessibility of gambling, marketing, and feminised gambling products being accredited for encouraging their gambling behaviour (McCarthy et al., 2020).

Drawing from the tobacco industry, where targeted research, policy and practical initiatives have been employed to reduce smoking in women, researchers advocate for a gendered approach to public health research, policy and practice strategies to tackle gambling-related harms and develop measures and interventions that are salient for female gamblers (McCarthy et al., 2019). Both a research agenda to minimise gambling harm for women and the provision of regulatory directions and female-tailored policies are needed. Practical strategies, such as educational campaigns and alternative community-based activities, including alternative leisure activities or safe alternative venues (McCarthy et al., 2019) could further prevent gambling-related harms in women. Additionally, moving away from messages of individual responsibility to those

highlighting the risk of gambling could help correct older women's risk perceptions. For young women in particular, researchers and policymakers need to pay closer attention to how they become a target market for the gambling industry and how to implement strategies to prevent gambling-related harm (McCarthy et al., 2020).

Note for health professionals/ practice:

> Practitioners also need to pay closer attention to how women become a target market for the gambling industry and how to implement strategies to prevent gambling-related harm.

Treatment

Cognitive Behavioural Therapy (CBT) and Motivational Interviewing are the recommended treatments for harmful gambling according to the most recent Cochrane review (Cowlishaw et al., 2012). However, men have been over-represented in treatment outcomes of the male-centred model for harmful gambling. In particular, the Cowlishaw et al. (2012) drew on 14 RCTs, over a third of which relied on male-only or male-dominated samples, while only one considered solely females (Dowling et al., 2007), and one had a balanced sample (Abbott et al., 2012). As a result of the limitations in the research, Monash Guidelines (National Health and Medical Research Council, 2011) did not make recommendations about the effectiveness of interventions for female gamblers. A more recent study in New Zealand has shown evidence for the efficacy of CBT and MI using a good gender balance of participants, but further investigation is recommended (Bellringer et al., 2022). Similarly, a small study found preliminary evidence for the effectiveness of the opioid antagonist naltrexone in reducing craving, but only 10% of the

treatment sample were women (Ward et al., 2018), which is typical of the slim representation of female gamblers in treatment populations (Brand & Wohr, 2017; Mooney & Kaufman, 2017; Slutske, 2006).

Research on treatment specifically designed to meet the needs of female gamblers is scarce (Dowling et al., 2007; van der Tempel et al., 2020). One study that evaluated individual and group-based CBT delivered to female gamblers found that both types of treatment produced comparable outcomes that were superior to the control group. The individual CBT also produced superior outcomes in terms of psychological functioning and more long-lasting effects at the six-month follow-up (Dowling et al., 2007). Another study investigated the feasibility and therapeutic potential of a 10-week mindfulness-based group intervention with a small sample (n = 9) of females gambling problematically, finding that the group achieved clinically and statistically significant decreases in both gambling-related measures and depression (van der Tempel et al., 2020).

Despite the scarce evidence of gambling-related interventions tailored to female gamblers, barriers to treatment are well-documented for this client group across various settings (Kim et al., 2016; Mooney & Kaufman, 2017; Rogers et al., 2019). Data obtained from the National Problem Gambling Clinic (NPGC) in the UK highlights that women are less likely than men to attend an assessment (70% compared with 81%) and more likely to cease treatment (Mooney & Kaufman, 2017). Female gamblers presenting with higher comorbidity in clinical samples (see Andronicos et al., 2015) may have accounted for women's higher dropout rates. Another study revealed gender differences in the use of a helpline; despite women reporting greater problem severity and distress, they were less likely to access treatment afterward (Kim et al., 2016). The authors attributed this finding to male callers having been significantly more likely to attend Gamblers Anonymous (GA)

meetings while women would not because they did not necessarily feel comfortable in the male-dominated environment of GA meetings (Kim et al., 2016). Likewise, in a recent scoping review addressing the experiences of women who attend GA, a range of barriers to participation were identified, including "external" barriers like lack of referral and signposting, lack of accessible meetings and cost of travel, as well as "internal" barriers, including shame, stigma and fear of disclosure (Rogers et al., 2019).

These results indicate that several different methods may be needed to engage women in treatment, with some clinical experts arguing for a strong relational and emotional element to treatment for female gamblers. Some clinicians emphasise the role of group therapy in helping women to create safe and trusted attachments, and eventually help them replace their attachment to gambling (Karter, 2014). Others also advocate that female gamblers can benefit from a group, which is not focused on addiction but on women's issues, where they feel heard, also highlighting the therapeutic value of relational elements in treatment (Prever & Locati, 2017). It has also been recommended that emotional issues and coping mechanisms need to be the focus of interventions for female gamblers (Grant & Kim, 2002; Jindani et al., 2021).

It is also likely that women feel uncomfortable in treatment settings because they are male dominated (Althaus et al., 2019). As female gamblers have often experienced previous adversity and trauma and their gambling is driven by different motivations than men, they may find it more difficult to feel safe in mixed-gender treatment groups (Brand & Wohr, 2017). If this is the case, women-only treatment programmes may lead to better treatment outcomes than mixed-gender ones. Reflecting on the telescoping effect in women, targeted interventions early in their gambling career may be necessary. Finally, practical barriers related to childcare and fear of social services

being involved could magnify feelings of guilt, in which case anonymity in services may be helpful.

At the NPGC, only 25% of the clients referred to the clinic in 2021 were female. This male-dominated picture is consistent to that found in the literature. An 8-session CBT protocol adapted by Petry (2005) for the treatment of harmful gambling is offered in the form of individual or group sessions as our first-line treatment. Clients who would like to address the underlying causes of their harmful gambling after completion of CBT, or those declining CBT, are offered psychodynamic therapy (which is described and evaluated elsewhere; Mooney et al., 2019).

Between April 2020 and November 2021, 20% of the clients seen for CBT and 15% of those seen for psychodynamic therapy were female. The low percentage of female clients attending psychodynamic therapy goes against experts' opinions that treatment with a strong relational element would be more appealing for female gamblers. However, data from a larger sample are needed before we can draw more definite conclusions. Previous attempts to offer female-only CBT groups at the NPGC have not yielded promising results, with such groups dissolving prematurely. Female clients presenting with a more complex clinical picture and barriers related to childcare may have contributed to this result. Overall, we have found that most female clients benefit more from individual than group treatment, where greater flexibility in treatment can be offered.

Note for health professionals/ practice:

Research on treatment specifically designed to meet the needs of female gamblers is scarce but some clinical experts argue for a strong relational and emotional element to treatment. Women-only and individual treatment programmes may lead to better treatment outcomes.

Conclusion

The fact that being male gender is a risk factor for harmful gambling has contributed to a well-recognised male bias in the gambling literature. However, there has been an increased trend in the rates of gambling among women, with female gamblers making up a third to half of the gambling population, depending on the country. An ever-evolving gambling landscape, shift in social roles and targeted marketing may have all contributed to these changes. Women's gambling career appears somewhat distinct, with a possible telescoping effect resulting in women starting to gamble later in life and developing a problem earlier. Women, who traditionally prefer chance-based games, seem to engage in a narrower range of gambling activities than men.

Women's clinical and psychological profile also seems to be distinct from that of male gamblers. Female gamblers often present with higher rates of psychological comorbidity, especially in clinical samples. However, a more mixed picture emerges in gender-based comparisons in community samples, where female gamblers do not always present with more complex clinical pictures, which could also reflect the increased popularity of gambling among women. With the exception of the increased likelihood of female gamblers who smoke nicotine products, there is no other clear substance-use profile for gambling women replicated consistently across studies. There is some evidence to suggest that female gamblers have an increased risk of being a victim of relational violence compared to non-gambling women and male gamblers.

The motivation for gambling in women seems to concern fewer financial and enhancement motives, with gambling appearing to function as a coping strategy for an underlying vulnerability or feelings of isolation. Preliminary evidence suggests a genetic element, hormonal factors related to menstrual cycle, and neurocognitive mechanisms related to compulsivity underpin gambling

behaviours in women. Further research is needed before any conclusions can be drawn on biological mechanisms in women with gambling problems.

On a policy level, scholars have advocated for a gendered approach to public health research, policy and practice strategies to tackle gambling-related harms and develop measures and interventions that are salient to female gamblers.

Recommendations for treatment of harmful gambling have derived from research on mixed-gender or male-dominated samples. Research on treatment specifically designed to meet the needs of female gamblers is scarce. Barriers to treatment, including external practical barriers and internal shame-based barriers, are well-documented for female gamblers and can prevent engagement with treatment. Clinical experts have emphasised the need for strong relational and emotional elements to treatment for female gamblers—a feminisation of gambling treatment to be akin to the feminisation of the gambling industry. It would be interesting to gain insight into whether treatment in a female-only environment can improve engagement and outcomes.

Note for health professionals/ practice:

> Research on treatment specifically designed to meet the needs of female gamblers is scarce but some clinical experts argue for a strong relational and emotional element to treatment. Women-only and individual treatment programmes may lead to better treatment outcomes.

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