THE GAME OF BINGO: A REVIEW OF THE LITERATURE AND STUDY OF WOMEN PLAYERS IN ONTARIO

by

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Abstract

Research addressing problematic bingo play is sparse. Existing literature is reviewed and supplemented by this Ontario study of women bingo players versus slot players. It compares demographic, gambling patterns, personal and family histories and treatment needs. Bingo players belonged to more impoverished and marginalized groups. They reported higher levels of trauma, abuse, psychiatric issues and co-occurring problems, and different treatment needs.

Bingo plays an important role in the women's leisure lives. Findings suggest that social and economic considerations play a dominant role in determining game choice. A serious public health concern issues from the current closure of many bingo halls and migration of bingo players to slot play, which can deplete financial resources more quickly. The more limited resources of bingo players increase the risk of rapidly developing gambling problems, causing a ripple effect in both personal and social costs. Interventions should be formulated to specifically target these players.

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CHAPTER 1. INTRODUCTION

The little available research comparing players of different games of chance offers evidence it is an area needing more exploration. Dickerson (1993) suggests that different psychological processes may cause impaired control in different forms of gambling. Oliveira and Silva (2001) report distinct demographic differences in a comparison of Brazilian bingo, video and horse race players. Schellinck and Schrans (1997-1998) conclude from a Nova Scotia study that gamblers are not a homogenous group, that the game being played is important in drafting prevention and treatment initiatives.

Research specific to bingo players having problems related to the play is almost non-existent. Studies that include data on bingo often have small sample sizes. Most often no gendered analysis. One exception is the recent Provincial study called *Voices of Women who Gamble in Ontario: A Survey of Women's Gambling, Barriers to Treatment and Treatment Service Needs* (Boughton & Brewster, 2002). It included a large sample of female problem gamblers who play bingo. The current study further analyzes the data from the Boughton and Brewster study, comparing the women who played bingo and the women who played slot machines, looking specifically at demographics, gambling patterns and correlates, personal and family histories of addiction, mental health, abuse and co-occurring problematic behaviours. It also briefly considers barriers to treatment, service needs and issues. The study builds on current knowledge about bingo players as a special population of female gamblers. Ultimately the findings will help professionals shape outreach, prevention and programming development so as to be optimally effective in addressing the unique needs of its population of gambling women of Ontario.

CHAPTER 2. LITERATURE REVIEW

Bingo Prevalence

Bingo is popular in many parts of the world. It is predominantly played by women. A national survey in the United Kingdom identified bingo as the major leisure activity outside of the home for 73% of the women (Dixey & Talbot, 1982). A more recent (2004) survey in the UK found that 17% of adults over the age of 18 played bingo (Creigh-Tyte & Lepper, 2004). In Brazil most games of chance are outlawed, but the game of bingo has been legal since 1992 and is increasingly popular (Oliveira & Silva, 2001). In Australia bingo is a common form of gambling. Women's participation rates and weekly expenditures dramatically exceed those of men (Brown & Coventry, 1997, p. 18). Although a report by the National Opinion Research Center (1999) notes a decline in levels of bingo play in the United States since 1975 (from 19% to 6%) the percentage of women who play bingo is double that of men.

Across Canada bingo is played by 8% of adults (12% of women and 5% of men; Marshall & Wynne, 2003). It is generally more popular in the Atlantic region. Although gamblers may spend larger amounts of money per session at other games, bingo players tend to play more often, creating an aggregate of higher total expenditure. Marshall and Wynne (2003) report that bingo, although played by relatively few gamblers (8%), was the third most frequently played game (after lotteries and scratch tickets) with one in five playing at least once a week (p. 8). As recently as 2005 the highest average household gambling expenditure in most Canadian provinces was on bingo (Marshall, 2007). Ontario bingo players spent an annual average of $1,298 compared to an annual gambling expenditure of $654 by players at casino slot machine and Video Lottery Terminals (VLT). Gender and age differences are apparent. Women of all age groups in one-person households spent more on bingo than any other form of gambling. This was most notable with the younger women (ages 18-44) and older women (age 65 and older). The younger women spent an average of $2,263 on bingo (compared to $259 at casinos or on slot machines or VLTs). The older women spent an average of $769 on bingo (compared to $466 on casinos, slot machines or VLTs). By contrast, only men aged 65 or over

spent more on bingo ($563) than other forms of gambling, with their second highest expenditures being on lotteries ($446).

Perspectives on Bingo

Population studies indicate increasing levels of gambling and problem gambling by women (Adlaf & Ialomiteanu, 2001; National Opinion Research Center, 1999). Although bingo specific research is limited, a few studies exist. They offer different perspectives on the game of bingo and the players.

Social and Leisure Studies

Back in 1982 Dixey and Talbot (see also Dixey, 1987) used an ethnomethodological approach focusing on women in the United Kingdom (UK) to explore bingo from a social and leisure perspective, The study addresses the differing social perceptions of the game of bingo. Dixey (1987) notes that bingo players are derided in the popular press, writing, "The stream of vitriol and the often patronizing way in which bingo players are treated is easy to document" (p. 199*).* Citing a series of news items exemplifying this, she comments,

> Much of this reaction is because bingo does not conform to what is regarded as a useful activity, it is a form of gambling, it is predominantly working class, and it is predominantly female. The reaction raises important questions for leisure studies, centering on questions of image and how certain activities are constructed as acceptable, approved and promoted. One of the reasons for bingo image is that the image makers are not bingo players…to the middle class bingo is an arcanum, or at least, that their knowledge of it is as a decontextualized activity (p. 200).

Dixey (1987) explores the meaning of bingo for female bingo players, arguing that the bingo club provides a moral community in which members care for and notice the welfare of others. For women of all ages the club provides something which no other facility offers: a largely female environment, non-intimate social contact, involvement in a game that requires no training or equipment, relaxation, the chance of winning, all in a building which is physically and culturally part of the community.

It is worth noting that Dixey and Talbot (1982) conclude that the women's play is not entirely a free choice. Women would prefer to engage in other activities if they had the opportunity; bingo is played not as a positive choice but due to a lack of alternatives: "If bingo does not owe its existence to the fact that it is the best way of satisfying people's (especially women's) demands for entertainment and excitement, it is still the only form of leisure outside the home available to large numbers of people - particularly women - at present" (p. 169). In short, the meaning of bingo is shaped by

social constraints on the lives of women, more specifically within the context of socio-economic and power limitations of working class women in the UK.

Wellness and Health Studies

Writing from a wellness perspective, O'Brien Cousins, Witcher and Moodie's (2002) mixed methods approach explores bingo as a positive element in the lives of older adults. The researchers' goal was to explore the "experiential meaning of a bingo way of life and its interface with the physical activity patterns, wellness and quality of life of older adults" (age 65 and older) in Alberta (p. 9). They found that seniors who play bingo tend to be older, female, and less healthy, of lower income and of lower education. Motives for playing include affordable entertainment, a means of filling time and bingo as a social outing. Bingo offers respite from loneliness and isolation, an escape and fills time. Sobel (2001) shows that bingo provides cognitive stimulation in treating Alzheimer's disease.

While O'Brien Cousins et al. (2002) observe that bingo, played by 15% of the Alberta senior population, can contribute to the well being of older adults, they conclude that the main reason older adults play bingo is because there is little else available for them. Their choices are socially constructed and essentially limited by their circumstances (age, gender, income and health). In a follow-up analysis of the data, O'Brien Cousins and Witcher (2007) propose that the gaming lifestyle of older adult bingo players has "less to do with habits of smoking, eating poorly, drinking alcohol, or having excessive leisure time, and more to do with sedentary recreation that is socially delimited by their gender, age, income and health" (p. 95). The main lifestyle vice of players was inadequate levels of or no physical activity at all (p. 107).

Bingo and Superstition

Some bingo specific studies focus on superstitious behaviours. King (1990) uses an ethnographic approach to study the use of superstition and magic by female bingo players to increase winnings and neutralize the self-interest aspect of the game. Griffiths and Bingham (2000) explore superstitious beliefs of bingo players using a quantitative methodology and convenience sample, distributing a questionnaire to 412 bingo players over four evenings in Nottingham, UK. Participants were primarily women (n=354). Twenty percent of the sample, generally the older women, played three to five times a week. Ninety-three percent of the sample came to the bingo hall with one or more friends or relatives. While the majority (81%) of the sample had at

least one superstitious belief, only 10% indicated that they were superstitious while playing bingo. Frequent bingo players were more likely to believe in fate and to be more superstitious while playing. They were also more likely to be young and also gamble at the fruit machines (an electronic slot machine) while at the club. More of the heavy spenders (14%) than the light spenders (6%) played bingo alone. Griffiths and Bingham (2000) argue that bingo is no longer a game dominated by the working classes; the presence of younger players, some in white collar professions (15%), marks a change in the social acceptability of bingo. The results also counter the findings of King (1990) that many bingo players use superstitious strategies in order to win, suggesting to Griffiths and Bingham that behaviours such as sitting in the same seat were merely part of a familiar social routine rather than being associated with "luck".

The Culture of Bingo

Ethnographic explorations of the bingo culture constitute another perspective on the game and the players. Chapple and Nofziger (2000) employed participant observation and informal interviews to generate a rich snapshot of the bingo culture. They describe the interplay of factors that serve to make it attractive to women in Arizona, looking at the act of playing bingo and the protocol or unwritten rules covering a wide range of issues such as seat selection, talking, eating and winning.

MacLure, Smith, Wood, LeBlanc and Cuffaro (2006) used a similar methodology to study bingo players in Ottawa, Ontario, employing a feminist lens of interpretation. They conclude that the satisfaction of bingo emanates from the social environment that women create around the game and from the various rituals and beliefs that their participation has engendered. From an etic perspective, they observe that women who frequent bingo halls usually are "well entrenched in their current social economic positions", with "no signs of upward social mobility among them" (p. 181). The fact that women spend winnings rather than use them towards long term goals is interpreted as a means of disempowering themselves. They write, for example, that, "Bingo is a parody of their socioeconomic situation, which is characterized by lack of economic and job related power and by a tendency to rely on the fortunes of fate. Surreptitiously therefore bingo may actually exacerbate the lack of control they have over these aspects of their lives" (p. 182). The researchers also offer an alternative emic perspective, acknowledging that it more aptly reflects the

thinking and motives of most of the women they observed. Bingo serves as a form of rejuvenation, a way in which the women can assert themselves freely: “From their own perspectives, by regularly engaging in what many conventional critics regard as a waste of time and money, these women are asserting their independence of choice and action within a broader structural context that imposes pervasive social cultural constraints on their daily lives” (p. 182).

It is worth noting that both of these qualitative studies observe “hints of deviance” among the bingo players. MacLure et al. (2006) suggest that bingo is a legitimate entertainment expense for women who are relatively well off with no dependents (generally senior citizens) but that money is a source of worry for other women, especially among those in low income brackets and with family responsibilities. Some women expressed guilt and shame, admitted that they conceal the amount of time and money they spend on bingo from family members, and worried about their relations with their children. Chapple and Nofziger (2000) “uncovered behaviour that casts doubt on the harmless status that this group enjoys” and write of the involvement of many bingo players with “imprudent acts” of drinking, smoking and other forms of gambling. Although they did not gather much observational data on problem play, they do report that some informants felt distressed about the bingo playing.

The Meaning of Bingo

As a methodology, phenomenology aims to describe the “meaning for several individuals of their lived experiences of a concept or phenomenon” (Creswell, 2007, p. 57). Focusing on commonalities, the researchers’ basic goal is to develop a composite description of the universal essence of the experience.

A phenomenological study in North West Ontario by Berry, Fraehlich and Toderian (2002) focused on women’s perceptions of their gambling behaviour. The researchers write from a feminist perspective, observing that there has been little attempt to connect gambling behaviour to the reality of the social context of women’s lives (p. 17). The study involved a triangulation of multiple sources of data, which included 36 interviews with phone-in callers, 17 of whom were then recruited for in-depth interviews. Unobtrusive observations at three casinos and a bingo hall allowed the researchers to describe both the context and the players. Secondary data were provided by information extracted from 35 clinical files of women gamblers who had

been in treatment at the Lake of the Woods Addiction Services in Kenora over a two-year period (from June 1, 1999 through May 31, 2001).

The emic perspective of women's motivation for gambling provided by the researchers captures the functional role of gambling as described by the women: fun, excitement, social, escape, stress relief. The etic perspective (interpretation) offered by Berry et al. (2002) draws on the work of Van Den Bergh (1991), who promotes the position that "all addiction is rooted in patriarchal capitalism". They write:

> Most western societies value conquest, competition and the acquisition of material wealth. People are, therefore, predisposed to believe they are not good enough, just as they are. Van Den Bergh believed women are especially at risk for addiction because of economic oppression, victimization, and sex roles stereotypes. They usually have less access than men to material wealth; physical and sexual abuse create shame, guilt, and resentment in many women; and women's stereotypical role is as dependent caregivers in a society that does not value caregiving. Van Den Bergh noted that women may feel inferior, isolated, and powerless, and this may cause them to turn to external substances and self defeating behaviours in order to feel better about themselves (p.18).

Notable for the purposes of this study were differences between women for whom information was collected through the treatment files and the women who were interviewed. Women in the treatment sample were less likely than women in the interview sample to be married or in relationships; more had children and were single parents. They also had lower levels of education and a larger proportion was not in the paid work force. In addition, more of the treatment sample than the interview sample had experienced abuse, and many had multiple addictions. A larger proportion of the treatment sample were aboriginal (28 of the 35) compared to the interviewees (2 of the17). Bingo emerged as the most popular gambling activity among the treatment sample (n = 27) although they also engaged in electronic gambling in the form of Video Lottery Terminals (VLT) and slots (n = 20). In contrast, the most common form of gambling for the 17 interviewees was electronic gaming (n = 15) followed by bingo (n = 11).

Problematic Bingo Play

Although our information about the impacts of problematic gambling on women who play bingo is enriched by the study of Berry et al. (2002), bingo has been generally overlooked in problem gambling research (O'Brien Cousins et al., 2002). No studies that focus exclusively on problem bingo play exist. Wynne's (1994) secondary analysis of female problem gamblers in Alberta takes on special

importance, not only for its focus on women, but also in drawing to our attention the problematic potential of the game of bingo for women. The sample had 49 female problem gamblers, 37 of whom played bingo.

Some information on problem bingo play emerges in the context of general gambling research. These are generally limited to population surveys. Sample sizes are small and a gendered analysis is rarely provided. An Ontario population study by Wiebe, Single and Falkowski-Ham (2002) had a sample of 165 problem gamblers (91 male and 74 female), some of whom played bingo, but a gender and game based breakdown of the findings is not provided. A study of senior gambling in Manitoba by Wiebe (2002) involved a sample of 28 problem gamblers, only 6 of whom played bingo, gender unspecified. Thus our information from population studies on women who play bingo at a problematic level is best described, to borrow from Wynne (1994), as “impressionistic”. Studies on specific populations such as older adults, youth and Aboriginal groups supplement our knowledge.

Special Population: Older Adults

Gambling by seniors is an area of study receiving increasing attention. Munro (2003) provides a summary review of the literature. Studies of gambling by older adults find bingo to be a common pastime. McNeilly and Burke (1998) surveyed 49 activity directors working with senior programs. A quarter (23%) of the older adults was reported to play bingo on-location more than four times a week, and 16% went on day trips to casinos more than once a month. The researchers observe that some casinos operate bingo rooms as a means to “bring in players who might not normally visit a casino, such as elderly women” (p.1) A New Brunswick survey by Focal Research (Schellinck, Schrans, Walsh & Grace, 2002) reports that, except for Lottery and scratch tickets, older adults are most likely to be playing bingo, with 8% playing on a regular basis during the previous year. Moreover, bingo is the only gambling activity for which trial increases with age.

Another study by McNeilly and Burke (2000) looked at demographic information, depression, life satisfaction, motivations for gambling and attitudes towards gambling among 315 older adults sampled from within the community (*n* = 224) and from bingo (*n* = 45) and casino (*n*=46) venues. The largest percentage of the gambling groups (*n* = 91) were Caucasian women (69%). Eleven percent (11%) scored as problem or pathological gamblers on the SOGS. Although the researchers

do not provide a gender breakdown or distinguish bingo from slot players, they do note that bingo players were significantly more likely to be playing once a week or more (41%) than were the casino players (28%). The average spending each time was less ($12.16) than the average spent by casino patrons ($53.12). There was no significant difference in depression and life satisfaction between these two groups.

The literature suggests that gambling declines with age and older adults are less likely than the general population to gamble at problematic levels (Wiebe, 2002; Schellinck et. al., 2002). However, a Chicago study reports a dramatic increase in gambling prevalence in adults 65 and older, swelling from 35% to 80% between 1975 and 1999 (National Opinion Research Center, 1999). McNeilly and Burke (2000) challenge the reports of a decline in gambling propensity and problem play among seniors, arguing that their results suggest that there may be higher levels of disordered gambling among older adults sampled at gambling venues than previously reported, levels "reflective of a largely unrecognized public health problem of problem gambling among older adults" (p. 412). This concern is echoed by Levins, Dyer, Zubritsky, Knott and Oslin (2005) who surveyed a random sample (n = 843) of older adults accessing a health care clinic. Although the nature of the gambling is not provided, 70% of the sample had gambled in the past year and 11% were identified as at risk for gambling problems.

Older adults can be particularly vulnerable to gambling related problems because of limited incomes. Petry (2002), reports that the older female gamblers in her treatment sample wagered the greatest amount of any age group in the months prior to treatment entry, in excess of 200% of their incomes (p.95). The financial impact on seniors of bingo play is a concern identified by Govoni, Frisch & Johnson (2001) who note that 27% of Ontario seniors live off a Guaranteed Income Supplement, and calculate that these seniors will use up 10% of their annual income if they play only 2 games of bingo a month.

Promotional efforts to attract players include numerous incentives and free transportation and senior women are specifically targeted. Tarras, Singh and Moufakkir (2000), for example, report on a study for the gaming industry on the feasibility of increasing revenues by appealing to the female senior segment of the population, concluding that the market is largely untapped. In a questionable interpretation of their data, they also suggest that "elderly women gamblers are

disciplined and do not suffer from compulsive gambling problems" (p. 33), a conclusion at odds with the figures they provide.

Special Population: Youth

Gambling is identified as a growing concern among youth. Gupta and Derevensky (1998) report on a survey of 815 adolescent high school students in Montreal. Adolescents reported participating in gambling behavior more often than any other addictive behavior, including cigarette smoking, alcohol consumption, and illicit drug use. Gender differences were evident. Males engaged in gambling activities more than females and were more attracted to sports lottery tickets and sports pool betting; females were more attracted to lottery tickets and bingo. The rate of pathological gambling was almost five percent.

A study in the United States by Volberg (2003) reports that more than half of young people (53%), ages 14 to 22, gamble in an average month; 20% of youth (gender unspecified) played bingo. Private forms of gambling (card games, sports betting, and bingo) dominate early gambling experience prior to age 18. In this study bingo was designated as a private form of gambling because age restrictions are rarely enforced and many families do not view bingo and other charitable gambling activities as true gambling. Bingo was most common among the youngest respondents but declined with age as youth became more involved in gambling with peers and in public venues (p. 3). About 8% of young people ages 14 to 22 were at risk for the development of problem gambling.

As with senior populations, the gaming industry is targeting youth. An article by Farouky (2003) describes successful efforts to modernize, reporting that industry officials spend tens of millions making bingo halls more youth-friendly and installing state-of-the-art equipment. She cites a marketing director of one of Britain's largest bingo operators as saying, "Bingo is the only female-dominated leisure pursuit. We target women in their mid-to-late thirties because they're equally happy to go along with their mothers or sit alongside someone who's 19. It's a secure environment, as opposed to others that are male-dominated like clubs and pubs".

Special Population: Aboriginal

The limited available studies of gambling among Aboriginal populations indicate that Aboriginal people face higher than average risks of problem gambling. Compared to non-Aboriginal populations, Aboriginal populations are 2 to 5 times

more likely to be problem gamblers and 4 to 16 times more likely to be pathological gamblers (Wardman, el-Guebaly & Hodgins, 2001; National Council of Welfare, 1996). A recent study by the Ontario Federation of Indian Friendship Centres (OFIFC, 2000) found that 46% had some problems and 22% were pathological gamblers.

Bingo figures prominently in Aboriginal gambling. Bingo was the most popular activity with the highest prevalence rate (89%) in an Albertan study of heavy gamblers, S*pirit of Bingoland: A Study of Problem Gambling among Alberta Native People* (Nechi Training, Research and Health Promotions Institute, 1994). In Aboriginal communities in Ontario, both on and off reservation, bingo is the game played most frequently and having the highest average monthly gambling expenditure (Nechi Training, Research and Health Promotions Institute, 1994; OFIFC, 2000). While these studies do not provide a gender-based breakdown, they do note the increase in problem gambling and the high incidence of female problem gambling. The predominant profile of a gambler emerging in the OFIFC (2000) study was that of a woman over the age of 39, living in a large urban center. Data on gambling treatment service utilization in Ontario (Rush & Moxam, 2001) reveal that bingo is identified as problematic by 43% of Aboriginals accessing services (compared to 18% of white and 2% of Asian populations accessing services).

The "Typical" Player

Despite the limitation to the research involving bingo players, the cumulative evidence does identify problematic bingo play among diverse populations of women gamblers. A general population study by Wiebe et al., (2002) confirm this, finding the percentage of Ontario bingo players having moderate or severe gambling problems (13%) to be higher than that of slot machine players (7%). Almost half of the Ontario women seeking gambling treatment in 2001 (46%) identified bingo as a problem game (compared to 10% of the males), second only to problematic slot machine play (55%; Rush and Moxam, 2001)

Summing up, the literature identifies bingo players as predominantly women. Many bingo players are from socially and economically disadvantaged segments of the population. They are more likely to be undereducated, underemployed and in lower income brackets. Many belong to marginalized populations such as aboriginal groups and populations struggling with mental health issues. Both youth and seniors,

populations known to be highly vulnerable to develop gambling related problems, often play bingo.

Feminist researchers have posited that women's choice to play bingo appears to be in large part socially constructed and contextualized. The social construction of the bingo is intergenerational. Players are typically introduced to the game at a young age by mothers or relatives (Dixie, 1987). Despite the stigma attached to bingo (O'Brian Cousins & Witcher, 2007; Dixey, 987), it plays a valuable role in the lives of many women of limited means, offering a social forum, a respite from stress and responsibilities, hope for financial gain and a comfortable safe place to gather.

Game Characteristics and SES of Players

Extant gambling literature notes the association of certain forms of gambling with different socio-economic classes. Oliveira and Silva (2001) report distinct demographic differences in a comparison of Brazilian bingo, video and horse race players (see also Dixey, 1987; Walker, 1992). Players of the game of bingo appear to be most concentrated in populations that are marginalized by cultural, age or socio-economic considerations.

A supplemental perspective in comparing players of different games of chance is to consider psychological and game characteristics (Brown & Coventry, 1997; Potenza, Steinberg, McLaughlin, Wu, Rounsaville, & O'Malle, 2001). Boughton (2003) for example, has argued that gender differences in preferred games are related to masculine and feminine orientations to the world. She cites Tannen (1990) who writes, "Men engage the world as an individual in a hierarchical social order in which he is either one up or one down. It is a world of status where independence is key. Women approach the world as an individual in a network of connections. Life is community, a struggle to preserve intimacy and avoid isolation". Boughton cites evidence that the typical gambling choices of men and women fit this pattern. Masculine tendencies to promote oneself in a hierarchy by beating other players or showing a superiority of skill are facilitated in card games, sports betting and handicapping. Feminine priorities of connection and intimacy are better met in games where winning is not at the direct expense of others. Women are more concerned that they be liked than they are with jockeying for status, prone to be less combative and to choose games of chance. Women are more likely to gamble in a social context where relationships are nurtured. Bingo, slots machines and scratch tickets, the

preferred games of female gamblers, offer this opportunity. She cites Dixey's (1987) observation that bingo winnings are usually shared which becomes a way of sustaining special networks. .

While Boughton's argument may have merit for understanding gender differences in gambling choices, it does not explain why some women choose bingo and others choose slots. In a search for different psychological processes that may cause impaired control in different forms of gambling. Dickerson (1993; see also Griffith, 1999) suggests that both internal factors (moods, emotions, cognitions, personality) and external factors (game characteristics, reinforcement schedules, stimulus conditions) are determinants of impaired control. Players have different subjective emotional and cognitive experiences of different games. Dickerson compares poker machines (slots) with off-track horse betting, noting that the elements of skill and continuity are different between the two forms of gambling.

In contrast to Dickerson's sample, however, the games of bingo and slot play are more similar than different: Both are luck-based games. The characteristic patterns of continuous reinforcement make them among the most highly addictive forms of gambling. Both games lend themselves to superstitious behaviours and fantasized hope, and readily offer the distraction or disassociated escape that is commonly identified as a motif in the problematic gambling of women (Blaszczynski, 2000; Brown & Coventry, 1997; Jacobs, 1989, 1993; Jain, Turner, Muglia & Spence, 2002; Lesieur & Blume, 1991; Mark & Lesieur, 1992). In short, these perspectives do not elucidate what distinguishes the women who play bingo from those who play slots or offer more substantive models than the socio-economic interpretations considered above.

This study adds to the current body of knowledge about problem bingo players. It analyzes data gathered in a recent Ontario study (Boughton & Brewster, 2002) of 363 women who were gambling at a level causing problems but were not in treatment. Consistent with the research literature on women encountering gambling related problems, the study revealed high levels of mental health, addiction, co-occurring problems and abuse in the personal lives and family histories of female problem gamblers (Boughton, 2003; Boughton & Falenchuk, 2007). This secondary analysis compares women within the sample who play only bingo (n=69) with women who play only slot machines (n=96) to further explore whether there are significant differences between players of different games that need to be factored

into our prevention, outreach and treatment considerations. The emphasis in this report is on the bingo players, how they may differ from slot players, and the implications of these findings.

CHAPTER 3. METHODOLOGY

Female gamblers who play bingo or slots may have different demographic profiles and experience gambling and gambling problems differently. The comparative analysis of the data will investigate the following areas of potential differences between the two groups of players:

1. Demographic profiles (levels of education, income, age),
2. Gambling behaviours (gambling activity, amount gambled, level of problem gambling, debt levels and percentage of income gambled),
3. Personal and family backgrounds (mental health issues, physical or sexual abuse, co-existing struggles with other problematic behaviours),
4. Reasons for gambling and perceived drawbacks,
5. Barriers to treatment and
6. Treatment service needs and issues.

Instruments

The original study, *Voices of Women who Gamble in Ontario: A Survey of Women's Gambling, Barriers to Treatment and Treatment Service Needs* (Boughton & Brewster, 2002), employed a mailed, self-administered questionnaire that was developed with reference to the existing literature and research on female gamblers. It was 46 pages in length and required an average of 2 hours to complete. It contained questions on demographics, gambling behaviors, family and personal history and treatment related issues.

The *South Oaks Gambling Screen* (SOGS; Lesieur & Blume, 1987) is a validated measure of levels of problem gambling. It is a 20-item screen based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III) criteria for a diagnosis of pathological gambling (American Psychiatric Association, 1987). The score is used to flag problem and pathological gamblers. A score of 0 means no problems, scores between 1 and 4 are interpreted to mean that the gambler is at risk for a problem or has a gambling problem and scores greater than 4 are interpreted to mean that the level of gambling is probably pathological. The SOGS identifies problems over the past twelve months (SOGS 12) and over a lifetime (excluding the past twelve months, SOGS Lifetime).

Participants

The target populations of the initial study was Ontario women who were gambling at a level that was causing them concerns but who were not currently in gambling-specific treatment. Subjects were recruited in a non-random process that primarily involved flyers and newspaper ads distributed across Ontario in locations intended to maximize the diversity of participants in terms of age, cultural backgrounds and sexual orientations. The self-selected sample of respondents was mailed a questionnaire with return postage. Most (85%) returned the completed form, providing a diverse and representative sample of 363 female gamblers. In exchange they received a $40 gift certificate selected from a number of options, (e.g., Loblaws, Zellers).

The respondents predominantly played lottery or scratch tickets, casino slot machines and bingo. The majority selected slots (35%) or bingo (35%) as their first choice or favourite game. Only a small proportion (9%, n = 34) did not play either game. Extracting from the larger sample women who play bingo but not slots (n = 69) and women who play slots but not bingo (n = 96) provides samples large enough to explore group differences.

Data Analyses

This archival study employed the statistical software SPSS (version 16.0). The analysis involved preliminary descriptive analyses and inferential analyses. Chi-square tests were used to explore the differences between the groups for categorical variables; t-tests, multiple regression, ANOVA and ANCOVA techniques were used for continuous dependent variables. Respondents did not always provide complete information, some questions were not applicable, some were presumably too personal (e.g., household income, history of abuse). When responses suggested that the questions were misunderstood, the responses were omitted. The reduced number of cases involved in these analyses is indicated.

CHAPTER 4. RESULTS AND DISCUSSION

Social Demographic Variables

Ministry of Health Regions

The bingo players (n = 69) and slot players (n = 96) lived in diverse regions of Ontario but the majority of the sample resided in Toronto (38%). Bingo players predominantly lived in Toronto (n = 36, 52%) and the North region (n = 12, 17%, Figure 1).

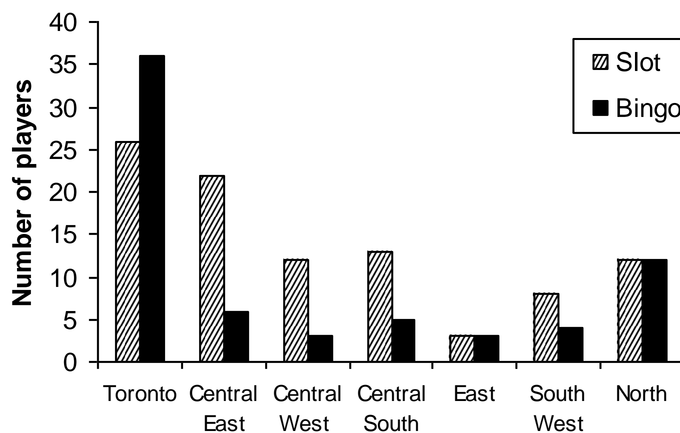

Figure 1. **Residency of slot and bingo players by Ontario Ministry of Health regions.**

Ethnicity

The original data included some diversity of ethnocultural backgrounds. These were collapsed into four groupings for these analyses. As can be seen in Figure 2, the majority of the bingo (79%) and slot players (86%) were Caucasian. While all of the Black women were bingo players, all of the Asian women were slot players. Some of the Aboriginal women played bingo (58%, n=7) and others played slots (42%, n=5).

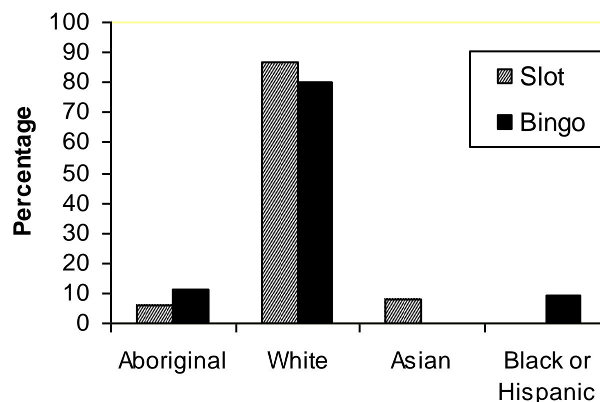

Figure 2. **Ethnicity of slot and bingo players.**

Age

An independent samples *t*-test evaluated the relationship between the women's age and type of gambling. Bingo players were significantly younger than the slot players, with a mean age of 42 years compared to a mean age of 48 years for the slot players, $t\ (163) = 3.22$, $p = .002$. The bingo players ranged in age from 23 to 66 years while the slot players ranged from 19 to 76 years. Both distributions were approximately normal. Cohen's *d,* which indicates the size of the difference between the ages of the two groups, is .5, indicating a medium effect size.

Education

A two-way contingency table evaluated levels of education as they related to the game being played. The two variables (education levels with four levels and type of game played with two levels) were found to be significantly related, $\chi^2\ (1, N=165) = 17.902$, $p = .000$. The effect size of *Phi* was .329, by convention a moderate effect size. Figure 3 is a clustered bar chart showing the highest levels of formal education achieved. The largest proportion of bingo players (42%) had a high school education; only 8% had any university education (compared to 35% of the slot players). This is comparable to the findings of a national study in the US, which noted that the percentage of players without a high school education is triple the percentage who are college graduates (National Opinion Research Center, 1999, p. 10).

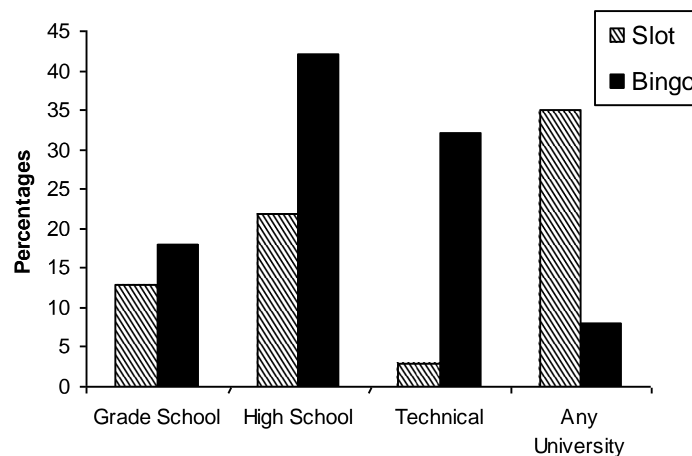

Figure 3. **Highest level of education of slot and bingo players.**

Marital Status

Marital status was evaluated with a two-way contingency table, using the variables of marital status with two levels and game played with two levels. Slightly more bingo players (45%) than slot players (42%) were married but the difference was not significant.

Employment and Unemployment

The relationship of employment status and game was also explored with a two-way contingency table. Overall, the groups were similar: 48% of bingo players and 60% of slot players were employed either full or part-time. However, for those who were unemployed, their unemployed status differs significantly. As indicated in Figure 4, larger proportions of the unemployed bingo players were on a disability pension (77% compared to 29% of the unemployed slot players). Larger proportions of the unemployed slot players were retired (54% compared to 10% of the unemployed bingo players); χ^2 (2, N=54) =14.3, p=.00. The *Phi* value measure of association of .514 was strong.

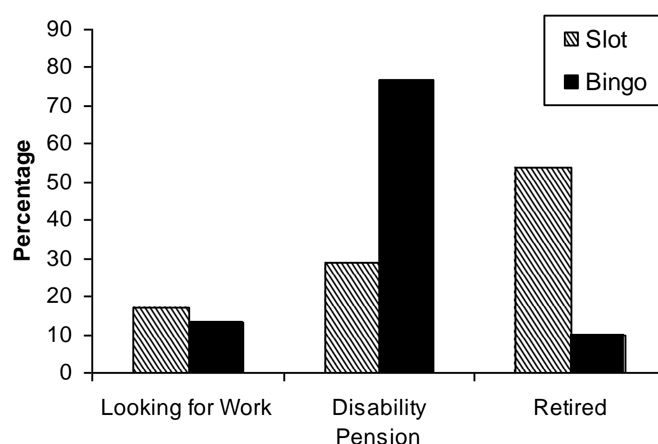

Figure 4. **Unemployed status of slot and bingo players.**

Personal and Household Incomes

Although not all respondents provided information on incomes, the available data on monthly net incomes were compared using *t*-tests for independent samples. As indicated in Table 1, personal incomes of the bingo players were lower than those of the slot players ($1429 vs. $1982), *t* (143) = 3.058. *p* =.003. Household incomes of the bingo players were also lower ($1804 vs. $2818), *t* (120) = 3.704. *p* =.000.

Table 1
Comparison of Incomes of Female Bingo and Slot Players

	M	*SD*	Median	Min	Max
Personal Monthly Income**					
Bingo Players (*n*=65)	$1429	$1,043	$1,200	$86	$6,000
Slot Players (*n*=80)	$1982	$1,112	$2000	$300	$6,000
Household Monthly Income**					
Bingo Players (*n*=55)	$1804	$181	$1,400	$374	$6,000
Slot Players (*n*=67)	$2818	$1,628	$2,500	$642	$9,000

*$p < .05$. **$p < .01$.

The effect sizes of the difference between the bingo and slot players, as measured by Cohen's *d,* was respectively 0.5 and 0.7 for the personal and household incomes. Although these are moderate to large effect sizes, it is important to be cautious about the results because of the missing data and the range of incomes reported. For example, a histogram of the personal net incomes of the bingo players

(Figure 5) shows that the distribution is positively skewed. It ranged from a minimum of $86 per month to a maximum of $6,000; the median was $1200. A histogram (Figure 6) of the personal net incomes of the slot players is also skewed. It ranged from a minimum of $300 per month to a maximum of $6,000; the median was $1400. However, a check of the data does not suggest an error in the data. The bingo player who reported a personal income of $86, for example, was a married 32-year-old Caucasian woman who is a homemaker with one child.

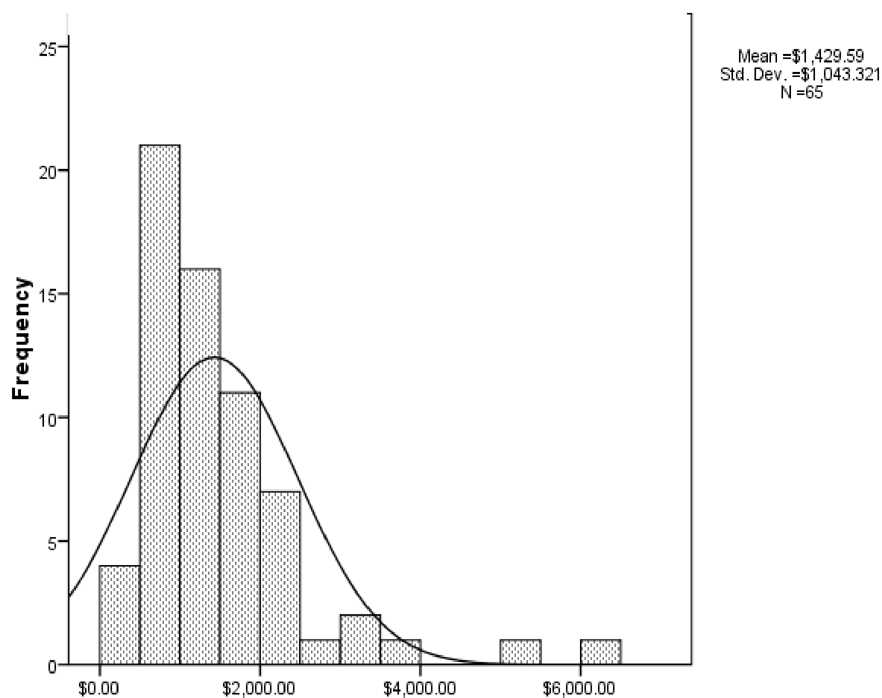

Figure 5. **Personal monthly income of bingo players.**

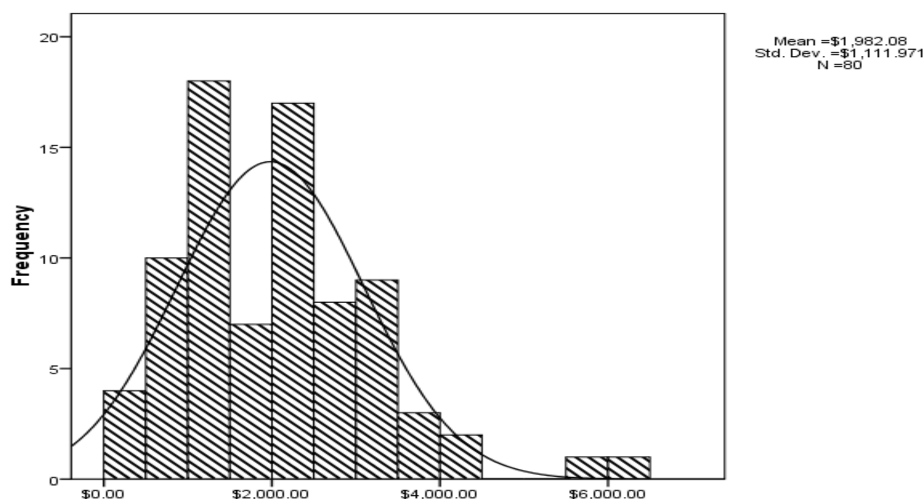

Figure 6. **Personal monthly income of slot players.**

Gambling Patterns and Expenditures

Gambling Expenditures

As shown in Table 2, the number of different forms of gambling engaged in by the slot and bingo plays did not differ; both groups participated in an average of three to four different types of games. However, a *t*-test for independent variables found a significant difference in total gambling expenditures, t (101) = 3.433, p = .001. The average monthly gambling expenditure (all games) for the bingo players was $527 whereas the amount for the slot players was $1,596. The effect size, as measured by Cohen's *d*, was medium (0.54),

Both bingo and slot players gambled a high percentage of their incomes. The bingo players gambled the equivalent of 47% of their net personal income and 40% of their net household income. The slot players gambled the equivalent of 80% of their net personal income and 66% of their net household income. *t*-tests indicated that only the proportions of personal income gambled were significantly different, t (102) = 2.036, p = .044, d = 0.341. (household income: t (92) = 1.643, p = .104, d = 0.300)

Table 2
Gambling Patterns and Expenditures of Female Bingo and Slot Players

Variable	Bingo Players (n=69)				Slot Players (n=96)			
	M	*SD*	Min	Max	*M*	*SD*	Min	Max
Gambling Patterns								
Mean number of different games	3.4	1.4	1	7	3.7	2	1	11
Frequency of play per month	7.8	7.7	1	48	4.6	5.1	.25	30.00
Expenditures								
Mean amount gambled each time	$40	$22	$6	$120	$201	$298	$5	$2,500
Amount gambled per month (all games)**	$527	$337	$15	$1,600	$1596	$3,022	$27.80	$20,000
Personal income gambled overall*	47%*	48.5	2.16	327	80%	136	.96	804
Household income gambled overall	39%	47.5	2.16	327	66%	118	.96	667
Debts								
Number of credit cards	2.4	2.2	1	10	3	2.9	1	20
Mean current debts*	$7,437	$18,742	0	$90,000	$11,555	$21,007	0	$115,000
Highest amount owed: Gambling debts**	$4,201	$10,511	0	$65,000	$10,351	$17,220	0	$100,000

* $p < .05$. ** $p < .01$.

Debt Levels

The majority, 68% of the bingo players and 62% of the slot players, indicated that they had, at some point during their gambling, accrued debts directly related to gambling. The groups did not differ on current debt levels or the number of credit cards they held. The highest amount of gambling-related debts they had ever had differed: Bingo players reported debts of $4,201 compared to debts of $10,351 reported by the slot players, t (97) = 2.231, p = .028, d = 0.447. Despite the lower levels of debt, the bingo players more often *agreed or strongly agreed* with the statement *there is not enough money to take of my basic needs* than did the slot players (50% vs. 28%), χ^2 (3, N=164) = 9.125, p=. *03*

Clinical experience in treating problem gamblers at the Problem Gambling Service (PGS) of the Centre for Addiction and Mental Health (CAMH) suggests that mounting debt as a consequence of gambling is often the catalyst that propels women into treatment. A t-test for independent samples, comparing the bingo and slot players within the sample who had never sought any form of treatment (n=80, 84%) and those who had at some point attended treatment or Gamblers Anonymous (n=20, 16%) substantiates this. The maximum money owed for gambling related debts for the women who had sought help was significantly higher than the average of the players who had not ($20,606 vs. $4,225), t (22) = 3.073, p = .006.

A brief comment: At first glance bingo players appear to have fewer negative financial consequences to their gambling. Despite playing more often per month than do the slot players (7.8 vs. 4.6 times) they spend less money per month gambling and a smaller percentage of their personal incomes. Their average gambling related debt is also lower, with bingo players having accrued debts of $4,201 compared to the $10,351 of the slot players. The impression, however, that bingo players appear to be less financially impacted by the gambling may be misleading; more limited incomes can make any excessive spending more of a financial stress.

Comparison of a Subset of Players Based on First Choice or Favourite Game

A separate analysis of a subset of women who identified bingo or slot play as their *first choice or favourite game* provides more information on playing patterns and social interactions. As is evident in Table 3, the average age that bingo players began to play was younger (age 24) than the age of the slot players when they began (age 40), t (125) = -7.16, p = .000, d = 1.30. On the other hand, the slot players

tended to play longer (4.3 hours vs. 3.2 hours) t (122) = -3.57, p = .001, d = 0.65. and to spend considerably more money each time they played than did the bingo players ($257 vs. $44), t (77) = -7.79, p = .000, d =0.88. The amount the slot players indicate as the *most they have ever risked* at one time is ten times as much as that reported by the bingo players ($995 vs. $100), t (78) = -4.27, p = .000, d = 0.78. The bingo players were more likely to report that they take home winnings (57% vs. 11% of the slot players), χ^2 (3, N=128) =31.2, p=. 000, Phi = .494.

Specific to social playing patterns, half of both sub-groups of players report that they *mostly or always gamble alone*. This is of some interest given the ethnographic research that emphasizes the social context of bingo (Chapple & Nofziger, 2000; King, 1990; MacLure et al., 2006; O'Brien Cousins et. al.2002). However, these qualitative studies were not focusing on problematic bingo play. Gambling often begins as a social experience but becomes asocial as problems develop (Boughton, 2003). This was also noticed by Chapple and Nofziger (2000) who observed that the "serious" bingo players did not talk to others. They describe an inverse relationship between the elaborateness of the shrines or charms used by bingo players and the amount of their socializing (see also Berry et al., 2002, Griffiths & Bingham, 2000).

Table 3
Gambling Patterns and Expenditures of Players Whose First Choice or Favourite Game is Bingo or Slot

	Bingo Players (n = 49)				Slot Players (n = 80)			
First Choice or Favourite Game	*M*	*SD*	Min	Max	*M*	*SD*	Min	Max
First game: Age began gambling	24	11	7	52	40	12.7	16	70
First game: Length typically play (hrs)	3.25	1.5	2	12	4.35	2.08	0.5	12
First game: Longest ever played (hrs)	8.6	4.3	3	24	11	9.7	2	48
First game: Amount risked each time	$44	$20	$16	$100	$257	$351	$20	$2,500
First game: most money risked	$100	$113	$20	$600	$995	$1,705	$25	$10,000
Amount gambled per month (all games)**	$527	$337	$15	$1,600	$1596	$3,022	$27.80	$20,000

Note. Some data was excluded on the slot play as a few respondents interpreted the questions to reflect coinage per slot spin (e.g., $1, $2,). This data was excluded from 6 cases. The averages on risk and spending per session are likely underestimates as amounts of minimum play of $25 were left in the data set but may also refer to coinage.

Access to Venues and Gambling Patterns

The women's patterns of gambling were related to venue proximity. At the time of the study there were over 200 bingo halls in Ontario, concentrated in the poorer, more densely populated areas of the cities. Slot or VLT machines in Ontario are limited to commercial and charity casinos and racetracks, which are generally located in more rural areas and the outskirts of cities and towns. As reported in Table 4, the bingo players more often accessed venues within walking distance from home (62% compared to 23% of the slot players). Conversely, the slot players more often gambled at venues that required up to two hours travel time (62% compared to 20% of the bingo players). Slot players were significantly more likely to both indicate that access determines frequency of their play and to play all night. The bingo players were more likely to gamble at regular times.

The availability of money determined play for both groups, with 67% of the bingo players and 55% of the slot players indicating they gambled whenever they have money. A portion of both groups indicated that they play more at certain times of the months, presumably related to pay schedules (bingo 45%, slot 40%). Both groups reported an increase in their spending over time, but the slot players were more likely to report that the gambling increases if they win (68% compared to 48%).

Table 4
Access and Gambling Patterns of Bingo and Slot Players

Access	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Gamble within…				
Walking distance	62	23	26.1**	.398
½ hour by car/ bus	42	58	1.0	.000
2 hours travel	20	62	27.6**	.409
Access Determines …				
How often Gamble	51	72	7.7**	.216
Type of Games	39	40	.0	.005
Gamble Whenever have Money	67	55	2.2	.138
Notice Increase in Spending	59	64	1.6	.099
Immune to Losses	51	58	.8	.071
Increase Play if Win	48	68	6.6**	.200
Play more at Certain times of Month	45	40	.5	.053
Play at regular time	44	26	5.5*	.182
Lose Interest if cut back	44	40	.2	.035
Gamble Through Night Sometimes	33	50	4.5*	.166
Cut back when Lose	29	41	2.4	.124

* $p < .05$. ** $p < .01$.

Variations in playing patterns between the groups likely reflected both socio-economic factors (e.g., access to a car, money) and the venue hours of operation. Although bingo players appeared to have more regular routines the fact that bingo halls are not open past 2 a.m. while casinos are typically open 24 hours a day would partly account for the differences. Expenditures may also be tied to the nature of the games: Slot play allows for spending limited only by the available resources. Players can move to machines of higher dollar values if they win. Bingo, by contrast, has some natural limits created by the number of cards the player is able to manage per session. However, the introduction of electronic bingo cards into Ontario bingo halls may soon eliminate the differences.

Level of Gambling Problems

Mean scores on the SOGS are indicated in Table 5. The majority (over 80%) of both groups scored as probable pathological gamblers (score > 4) on both the 12-Month and Lifetime indices. When the scores of the SOGS were compared to extract the highest score attained, past or present, the resulting profile shows similar levels of gambling problems for the slot and bingo players. Over 80% of both groups (84% of the bingo players and 80% of the slot players), had ever gambled at a pathological level, approximately 20% of both groups had ever been at risk (15% for the bingo players and 20% for the slot players) and only one percent of each group had never had a problem with gambling.

Table 5
Scores on SOGS and Levels of Problem Gambling of Bingo and Slot Players

Scores of SOGS	Bingo Players (n = 69)				Slot Players (n = 96)			
	M	*SD*	Min	Max	*M*	*SD*	Min	Max
12-Month SOGS Score	7.7	4.6	0	18	7.8	4.2	0	17
Lifetime SOGS Score**	8.3	4.6	0	17	5.8	4.8	0	17

* $p < .05$. ** $p < .01$.

While the score on the SOGS 12 of the slot and bingo players was not significantly different, t (163) = .106, p = .916, d = .016, the Lifetime SOGS score was higher for bingo players, t (163) = -3.54, p = .001, d =.559. Gambling has been more problematic in the past for bingo than for slot players. This makes sense in the context of the history of the games. Bingo has been in North America for circa 100 years. Bingo players often report that they began playing at a young age, introduced by mothers and relatives. In contrast, slot play has been available in Ontario for just over a decade.

Given the relatively recent introduction of electronic gaming machines (EGM, slot, VLT) into Ontario, the high levels of problem play among the slot players is a concern. Research involving gamblers who play electronic gambling machines shows that women rapidly develop gambling problems, more rapidly than men (a pattern called telescoping; Breen & Zimmerman, 2002; Tavares, Martins, Lobo, Silveira, Gentil & Hodgins, 2003; Potenza, Steinberg, McLaughlin, Wu, Rounsaville &

O'Malley, 2001). Tavares, Zilberman, Beites and Gentil (2001) found that the progression of the disorder was more than two times faster in women than in men. This is hypothesized by Boughton (2003) to be likely related to a combination of factors such as women's more limited financial resources and propensity to gamble as a coping strategy for emotional distress. Furthermore, game characteristics factor into the escalation of problems. Electronic gambling machines are considered to be among the most highly addictive forms of gambling because of the rapid play, intermittent schedules of reinforcement and phenomenon such as the "near miss" (Griffiths, 1999; Lindgren, Young, McDonald, Klenow & Schriner, 1987; Wildman, 1997).

Family History of Addiction and Mental Health

Consistent with research on female problem gamblers, a high incidence of addiction, mental health, and gambling problems was found in the family systems of both groups of women (Black & Moyer, 1998; Ibanez, Blanco, Moreryra & Saiz-Ruiz, 2003; Ladd & Petry, 2002; Lesieur, 1989; Lesieur & Blume, 1991; Mark & Lesieur, 1992; Martins, Lobo, Travares & Gentil, 2002). The results are shown in Table 6.

The levels of family psychiatric problems were similar for the slot and bingo players; 26% of bingo players and 17% of slot players reported that their mothers had mental health problems. These figures stand in sharp contrast to rates found in the Canadian population; the incidence of any mood disorder is 4.9% (3.8% for males and 5.9% for females) and incidence of any anxiety disorder is 4.7% (3.6% for males and 5.8% for females) (Statistics Canada, 2003).

Alcohol or drug problems within the family system are also high for both groups. Bingo players, however, were more likely than slot players to report having a mother with a drug or alcohol problem. Again the overall rates are substantially higher than in the Canadian population, where alcohol dependence in reported at 2.6% (3.8% for males and 1.3% for females), and any substance dependence at 3% of the population (4.4% for males and 1.6 % for females; Statistics Canada.2003).

Table 6
Family History of Addiction and Mental Health among Bingo and Slot Players

Family Member with Problem	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Psychiatric				
Mother	26	17	1.8	.105
Father	4	8	.7	.067
Sibling	26	21	.7	.064
Relative	26	19	1.3	.091
Drug/Alcohol				
Mother	38	22	5.1*	.177
Father	45	36	1.5	.096
Sibling	30	28	.1	.027
Relative	32	29	.2	.031
Gambling				
Mother	19	15	.4	.052
Father	20	11	3.0	.135
Sibling	17	14	.4	.049
Relative	30	15	5.7*	.187

* $p < .05$. ** $p < .01$.

Reports of gambling within the families of both groups indicate a high concentration of problem players. Ontario population studies suggest that from 1% to 4% of gamblers develop problem or pathological patterns of play (Wiebe et al, 2001). The bingo players were more likely than the slot players to report having a relative with a gambling problem. Overall, the findings of high levels of addiction, mental health and gambling within the family systems of both groups of players suggest strong social influences on shaping gambling and other potentially addictive behaviours.

Personal History of Abuse, Addiction and Mental Health

History of Abuse and Trauma

Approximately half of both groups reported having experienced trauma as adults (Table 7). Although the questionnaire did not explore the nature of the trauma, abuse is often traumatic. While both groups reported considerable emotional and physical abuse, the frequencies for the bingo players were significantly higher.

Table 7.
Abuse and Trauma Histories of Bingo and Slot Players

	Childhood Experience%				Adult Experience%			
History	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Abuse								
Physical	67	32	19.1**	.340	78	29	38.7**	.484
Sexual	62	26	21.0**	.358	53	19	21.1**	.358
Emotional	86	63	10.6**	.253	85	70	5.3*	.179
Religious	32	15	7.6**	.216	19	7	5.4*	.182
Financial	na	Na			63	38	10.0*	.248
Loss	65	45	6.0*	.192	85	84	.0	.013
Trauma	52	38	3.2	.139	57	48	1.4	.233

* $p < .05$. ** $p < .01$.

As children, bingo players experienced more abuse than did the slot players. Chi-square analysis reveals that over twice as many reported being victims of physical abuse (67% compared to 32%) and sexual abuse (62% compared to 26%). Levels of emotional abuse, religious abuse and loss (through death or separation) are also reported by the bingo players at levels significantly higher than those reported by the slot players.

These rates are higher than in the general population of Ontario, where rates of childhood physical abuse are reported to be 21% and childhood sexual abuse are 13% (Ontario Ministry of Health, 1990). Another Ontario study reports that 9% of females report a childhood history of severe physical abuse and 11% report severe sexual abuse (MacMillan, Fleming, Trocme, Boyle, Wong, Racine, Beradslee & Offord, 1997).

Turning to the women's experiences as adults, the bingo players, again, reported significantly higher levels of abuse than did the slot players. Over twice as many bingo players (78% compared to 29%) report physical abuse. Almost triple the proportion of bingo players to slot players report sexual abuse (53% compared to 19%). Reported levels of emotional abuse, religious abuse and financial abuse were also significantly higher for the bingo players.

The proportions of women indicating they had experienced abuse as adults were also higher than those found in the general population. Statistics Canada (2006) reports that 39% of Canadian adult women reported having had at least one experience of sexual assault since the age of 16. Women suffer from more severe acts of spousal assault than men and are more likely to be killed by a spouse: 7% of women living in a common-law or marital relationship had been physically or sexually assaulted by a spousal partner at least once during the previous five years (Statistics Canada, 2006). Aboriginal women in particular stand out as being at higher risk of spousal violence: 25% were assaulted by a current or former spouse, twice the rate for Aboriginal men (13%) and three times the rate for non-Aboriginal women and men (Statistics Canada, 1999).

The findings of high levels of abuse and trauma among female gamblers have been noted in other research. Although the sample was small (n=9), Kausche, Rugle and Rowland (2006) found that 100% of the women gamblers in their study reported some form of abuse. Another study of treatment-seeking problem gamblers found a significant gender difference, with women reporting more childhood abuse than men (Petry & Steinberg, 2005). The incidence of post-traumatic stress disorder (PTSD) among problem gamblers is estimated at 13% to 29% (Ledgerwood & Petry, 2006).

The Interaction of Age and Reported Abuse

The differences in rates of abuse reported by the bingo and slot players could be related to sample characteristics. Possibly the younger bingo players felt more comfortable about providing information on abuse or more socially conscious of the nature of abuse. Different perspectives and core values about privacy may be at work. Older adults can tend to be more private and may not hold more typical perceptions related to abuse, not identifying, for example, a childhood beating as anything other than discipline. Hirsh (2001) notes that seniors are most likely to seek out medical professionals if they have a personal problem: "Receiving counselling or burdening

others with one's problems is considered a 'weakness in character" (p.5). So too McKay (2005) writes of older women sharing histories of abuse: "Generally older women have not told anyone about these problems because they fear being judged, do no want to burden family or friends, experience emotional discomfort recalling painful memories and are uncertain about the value of sharing the information" (p. 41; see also Govoni, Frisch & Johnson, 2000; Sullivan, 2001).

It is also possible that the younger bingo playing women had actually experienced more abuse. Statistics Canada (2006, p. 36) reports that rates of violence are highest among the youngest women and decline with increasing age. A one way analysis of covariance (ANCOVA) was done to test the covariate of age as it may impact on the reporting of abuse. The dependent variable was continuous, a count of the total number of different forms of abuse reported by the bingo and slot players. The covariate was age. No significant interaction of age and reports of abuse were found, suggesting that the variations in ages of the bingo and slot players did not account for the finding of differences between the numbers of different types of abuse levels reported by the groups.

Concurrent or Past Problematic Behaviours

a) Current Issues

Many of the women struggled with additional problematic behaviors. As noted in Table 8, smoking and binge eating were the most common concurrent problems for both groups. However, the bingo players were more likely than the slot players to report smoking (63% vs. 39%) and the use of non-prescription drugs (18% vs. 7%). Although both groups report high levels of compulsive shopping, the bingo players were significantly more likely to report it as a current issue (38% vs. 19%).

Table 8.
Coexisting or Past Problematic Behaviours of Bingo and Slot Players

Problematic Behaviours	Current Issue: Bingo (n=69) %	Current Issue: Slot (n=96) %	Current Issue: χ^2	Current Issue: ϕ	Past Issue: Bingo (n=69) %	Past Issue: Slot (n=96) %	Past Issue: χ^2	Past Issue: ϕ
Smoking	63	39	9.0**	.236	84	56	14.6**	.298
Alcohol	7	8	.1	-.018	61	33	12.3**	.273
Prescription drugs	14	5	3.6	.150	30	13	7.5**	.215
Non-prescription. drugs	18	7	4.3*	.163	30	17	4.0*	.156
Disturbed eating								
Binge eating	27	27	.0	-.007	47	34	2.7	.128
Starving self	15	7	5.3	.179	35	15	9.6**	.242
Shopping	38	19	10.0**	.208	46	49	.1	-.026
Shoplifting	9	4	1.5	.097	31	16	5.7*	.186
Sexual behavior	13	6	2.4	.122	34	26	1.3	.089
Criminal activity	3	4	.2	-.031	19	6	6.4*	.198
Aggressive behavior	21	10	3.5	.146	44	30	3.3	.143

* $p < .05$. ** $p < .01$.

b) Past Issues

Past problematic behaviors were more common than current problems for both groups but bingo players struggled with a range of problematic behaviours more often than the slot players. The differences were striking, with bingo players reporting problems with alcohol, prescription drugs, shoplifting, starving themselves and criminal behaviour more than twice as often as slot players.

It is of interest that all problematic behaviors were dramatically more frequent as past issues than as current issues; as much as 54% in the case of alcohol. The explanation of the sharp decline is not clear. It could be a result of maturing out of certain behaviors, related in some way to treatment, a reflection of socially desirable responses and being more comfortable admitting to a past than current problem, or related to gambling, such as conserving money by reduced spending or a substitution of gambling for other problematic behaviors.

These high rates are consistent with other study results of female problem gamblers (Black & Moyer, 1998; Dannon, Lowengrub, Shalgi, Sasson, Tuson, Saphir & Kotler, 2006; Lesieur, 1989; Specker et al, 1996; Westphal & Johnson, 2000a). Overall, the rates of co-existing or past problem behaviours reported by both groups are higher than in the general population. For example, smoking among women has been reported at 21%, binge eating at 3%, compulsive shopping at 1% and alcohol abuse at 7% (Adlaf & Ialomiteanu, 2001; Christenson, Faber, de Swaan, Raymond, Specker, Ekern, Mackenzie, Crosby, Crow, Eckert, Mussell & Mitchell, 1994; Woodside, Garfinkel, Lin, Goering, Kaplan, Goldbloom & Kennedy, 2001).

Psychiatric Co-morbidity

A comparison of the mental health histories of the bingo and slot players revealed that a majority of both groups had sought professional help for depression and/or anxiety (Table 9). Bingo players report depression at 74% and anxiety at 63%. The bingo players reported seeking professional help for panic (38% vs. 23%), bi-polar mood disorder (22% vs. 8%) and anger (38% vs. 20%) significantly more often than the slot players.

Table 9.
Co-Morbid Psychiatric Issues of Bingo and Slot Players

Co-Morbidity	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Depression	75	67	1.3	.090
Anxiety	63	54	1.3	.090
Panic	38	23	4.5*	.166
Bi-Polar	23	8	6.4**	.199
Schizophrenia	6	3	.8	.069
Anger	38	20	6.8**	.204

* $p < .05$. ** $p < .01$.

While consistent with findings from other gambling research, these rates are considerably higher than those found in the general population. One in five Ontarians will experience a mental health problem in their lifetime (Statistics Canada, 2003).

The Canadian Mental Health Association (Zoutris, 1999) reports that 28% of Ontario women have experienced an anxiety disorder, 10% depression and 14% any affective disorder at some point during their lifetimes. These rates for women are significantly higher than those of men (p. 11). The yearly rate of major depression for women is about 6%, anxiety is 6%, bi-polar disorder is less than 1% (.05%) and panic disorder is 2% (Statistics Canada, 2003).

It is difficult to interpret the findings of such high levels of mental health issues in this sample of bingo and slot players. One possibility is misdiagnosis. Lehmann (2002), reports that many psychiatrists and mental health professionals misdiagnose the symptoms of abuse (including flashbacks, disassociation, mood fluctuations and impulsive behaviours) as psychosis or bipolar disorder. Lineham (1993a, 1993b) similarly reports a diagnosis of Borderline Personality Disorder (BPD) in women who are exhibiting symptoms of trauma as a result of abuse.

Predicting Problem Gambling from Abuse, Mental Health and Addiction History

As noted, the slot and bingo players reported high levels of mental health issues, abuse experiences and co-occurring chemical and "process" addictions (e.g., shopping, eating). Additional analysis, using a multiple regression to predict scores on the index of problem gambling, helped gauge the impact of these on levels of problem gambling. The independent variables included a count of types of sexual and/or physical abuse experienced as a child or adult, a count of the number of current or past behavioural and/or addiction issues, and a count of the number of mental health issues identified. The independent variables were entered in a predetermined order, which is shown in Table 10.

Table 10.
Multiple Regression Analysis with SOGS as the Dependent Variable

Hierarchical Step	Predictor Variable	Total R^2	Change in R^2	PRE	F* Change
1	Count Abuse	.046	.046	.046	7.841**
2	Count Mental Health	.091	.045	.047	7.955**
3	Count Co-morbidities	.161	.070	.077	13.522**

Note. The Proportional Reduction in Error (PRE) is the proportion of the remaining variance that is accounted for by this model. PRE = change in R squared/ 1-R squared C (compact or previous model).

* $p < .05$. ** $p < .01$.

The combination of these predictors accounts for 16% of the overall variance in the SOGS scores of the bingo and slot players. Sexual or physical abuse accounted for 4.6% of the variance, R^2=*.046, F* (1,164) = 7.841, $p< .01$, indicating that women who had experienced sexual or physical abuse as children or adults tended to have higher scores on the index of gambling problems. Mental health issues accounted for 4.7% of the remaining variance, R^2 *change=.045, F* (1,164) = 7.955, $p< .01$; the women with higher levels of psychiatric co-morbidity tended to have higher scores on the measure of problem gambling. Current or past behavioural or addiction issues accounted for an additional 7.7% of the remaining variance, R^2 *change=.070, F* (1,164) = 13.522, $p< .01$; bingo and slot players reporting multiple addiction or behavioural problems, past and/or present, tended to have higher scores on the measure of problem gambling. The results do suggest that histories of abuse, mental health struggles and problems with other behaviours are co-occurring elements in the development of problematic gambling habits.

Mental Health Correlates

Related to mental health concerns are the use of prescribed medications for emotional distress. No differences in usage were found between the bingo and slot players. Over 60% of both groups had been prescribed medications, and almost a third was taking them at the time of the study (Table 11). Although only a few reported being hospitalized (n = 35), the average number of hospitalizations over the past five years was higher for the bingo players (1.4 compared to 0.3), $t(33) = -2.55$, $p = .019$. The effect size (or size of the difference) as measured by Cohen's d is large

(0.87). Adding to a sense of the severity of their mental health concerns, bingo players were more likely to indicate suicidal behaviours: 62% report serious thoughts about suicide. More than twice as many bingo players as slot players had attempted suicide (50% compared to 22%).

Table 11
Related Mental Health Issues of Bingo and Slot Players

Mental Health Correlates	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Ever prescribed meds :Emotional distress	67	63	.3	.041
Currently on medications	41	31	1.6	.103
Hospitalized for emotional	29	19	2.3	.113
Serious suicide thoughts	62	43	5.5*	.184
Attempted suicide	50	22	13.8**	.291

* $p < .05$. ** $p < .01$.

The rate of suicide attempts (50%) of the bingo players are higher than the suicide attempt rate reported for pathological gamblers. Sullivan, Abbott, McAvoy and Arroll (1994) report that on a case review of 329 pathological gamblers who had called a New Zealand gambling help line. Most (92%) had contemplated suicide, 24% had planned suicide and 4% had made an attempt on their lives. Blaszczynski and MacCallum (2003) also report lower levels of suicidal ideation (36%) and suicidal attempts (8%) in a treatment sample of 85 problem gamblers.

Looking more closely at the data from the bingo players, it emerges that while 62% of the bingo players reported suicidal thoughts, only 10% indicated that suicidal ideation or attempts were *always or often a drawback to gambling*. The finding provides a strong argument that stress and dysphoria related to excessive gambling does not fully account for the high rates of suicidal behaviours, that a pre-morbid condition may be a factor. Suicidal behaviours and impulsivity, for example, are common among those suffering from bi-polar disorder. The National Institute of Mental Health (NIMH) reports the suicide risk for those with bi-polar disorder as 15 times that of the general population. Canadian suicide rates for individuals with depression or bipolar disorder are higher than in the general population

(approximately 5% versus 1-2%; Government of Canada 2006. p 63) Blaszczynski and MacCallum (2003) also noted that gamblers reporting suicidal ideation were more likely to be depressed than non-suicidal pathological gamblers but did not report more gambling problems. Newman and Thompson (2007) found that the odds ratio for pathological gamblers attempting suicide was 3.4 but were "surprised" to find that sex was not associated with attempted suicide. They suggest that the increased rate of attempted suicide among women may be largely owing to their greater prevalence of depression.

Reasons for and Drawbacks to Gambling

Reasons for Gambling

The bingo players in this study emerged as having quite distinct demographic backgrounds, family and personal histories from those of the slot players. Thus it was also informative to consider the reasons they gambled. The women rated on a 4-point Likert-type scale (1= *not important*, 2=*somewhat important*, 3=*very important*, 4=*extremely important*) 55 reasons drawn from the research on women's gambling. For this analysis, the data were collapsed into two categories by combining 1 and 2, 3 and 4.

Reasons endorsed by over half of the bingo and/or slot players are reported in Table 12. Consistent with the literature, the most common reasons are positive attractions of fun, winning money and excitement. Less positive reasons are also reported, reasons that illuminate why women are often referred to in the literature as *escape gamblers*. For large proportions of both groups, the gambling is related to mood management (e.g., *cheer myself up*) and stress relief (e.g., *get a break from responsibilities, escape problems or worries*). Needs for autonomy and reward are also common (e.g., *be free to do what I want, relax with something all my own, have time for myself, do what I want with my money*).

Table 12
Primary Reasons for Gambling of Bingo and Slot Players

Primary Reasons for Gambling (Very or Extremely Important)	Bingo (n=69) %	Slot (n=96) %
Fun	78	84
Win money	74	76
Feel excitement	71	81
Cheer myself up	68	59
Break from Responsibilities or work	60	46
Try my luck when I feel good	59	55
Be free to do what I want	58	54
Relax with Something all my own	58	48
Calm myself when upset	55	48
Escape problem or worries	54	48
Deal with boredom	54	47
Have time for myself	52	41
Do what I want with my money	52	44
Cope with anxiety	50	39
Get a break from reality	49	45
Feel hope	49	53

The women's motivations to *have time for myself* and *get a break from responsibilities* are consistent with the findings of an ethnographic study by Dow Schull (2002). She argues that gambling serves as an escape from what women experience as an excess of relational demands at home and work.

Despite the similarities, there were group differences. As can be seen in Table 13, the slot players endorsed only one reason for gambling more often than the bingo players: *entertainment*, (80% vs. 67%). Perhaps most telling given their personal and family histories, bingo players were more likely to endorse reasons related to emotional coping. More bingo than slot players selected *get relief from stress* (67%

vs. 51%) and *try to feel less depressed* (58% vs. 39%). To *deal with insomnia* was also an issue for more bingo than slot players, (20% vs. 8%). Other items distinguishing bingo players reflect strained relationships. They were more likely to gamble to *avoid tensions at home* (41% vs. 15%) to *avoid pressure from others* (30% vs. 17%) and to *be by myself* (41% vs. 21%), With a highly significant result, 22% of the bingo players gamble to do *my thing as my partner drinks/drugs* compared to only 2% of the slot players,. Perhaps related to this, more bingo players gamble to *treat myself to a good time* (55% vs. 37%). Likely related to socio-economic status, the bingo players were more likely to gamble to do *something affordable* (28% vs. 15%) and c*ontribute to family income (*35% vs. 18%). In short, for the bingo players, the gambling often appear to be a means of coping with considerable life stressors related to relationships and economics.

Table 13
Differences in Reasons for Gambling of Bingo and Slot Players

Reasons for Gambling (Very or Extremely Important)	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Leisure				
Be entertained	67	80	3.9*	.153
To treat myself to a good time	55	37	5.6*	.185
Reward myself	48	29	6.0*	.014
Stress Reduction				
Get relief from stress	67	51	4.3*	.161
Try to feel less depressed	58	39	6.1*	.192
Deal with insomnia	20	8	5.7*	.188
Relationship Tension				
Avoid tensions at home	41	15	14.0**	.292
Be by myself	41	21	7.6**	.214
Do my thing as my partner drinks/drugs	22	2	14.2**	.308
Avoid pressure from others	30	17	4.1*	.158
Financial Considerations				
Contribute to family income	35	18	6.1*	.193
Do something affordable	28	15	4.2*	.160

* $p < .05$. ** $p < .01$.

Thomas and Moore (2003) did a gender based analysis of the interaction effects of avoidance coping and dysphoric moods on problem gambling. For the female gamblers, loneliness, boredom, anxiety, depression and avoidance coping were all positively related to problem gambling. The higher incidence of gambling as avoidance or coping strategy by the bingo players may be related to these findings.

Drawbacks to Gambling

The women rated 60 drawbacks to gambling drawn from the literature. Items were rated on a Likert-type scale (1= *never an issue*, 2 = *sometimes an issue*, 3 = *often an issue*, 4 = *always an issue*). Again the responses are collapsed into two categories by combining 1 and 2, 3 and 4. As is evident from Table 14, the top dozen drawbacks identified by both groups are related to financial and psychological distress.

Table 14
Key Drawbacks to Gambling of Bingo and Slot Players

Drawbacks to Gambling (Often or Always an Issue)	Bingo (*n*=69) %	Slot (*n*=96) %
Financial Stress		
Losing money I can't afford	64	62
Stress over money loss	61	54
Worry about financial future	54	54
Taking money from other things	43	38
Psychological Distress		
Anger at myself or others	49	41
Depression as a result of gambling	49	46
Worry	44	38
Secrecy about time or money spent	44	45
Guilt	39	49
Breaking promises to myself or others	38	30
Fear/anxiety related to gambling	36	28
Loss of self-esteem	33	28

Financial concerns predominate: *Losing money I can't afford*, *stress over money loss* and *worry about my financial future* were identified as drawbacks by over half of the bingo and slot players. Another cluster of drawbacks relate to psychological or emotional distress: anger, depression, guilt, fear, loss of self-esteem. These results are consistent with research on the impacts of problem gambling.

Although the women generally endorse similar drawbacks, a few items distinguish the groups (Table 15). These fall into three clusters: financial threats to basic needs, self-care and relationships. The only drawback distinguishing the slot players was that of *cashing in investments* (20% vs. 3%). In contrast the bingo players were more likely to indicate problems with *evictions* (20% vs. 4%) and *loss of property to pawnshops* (24% vs. 3%). These differences likely reflect the differences in the financial resources of the players and underscore the differences in socio-economic status.

Table 15.
Significant Differences in Drawbacks to Gambling for Bingo and Slot Players

Drawbacks to Gambling (Often or Always an Issue)	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Threats to Basic Needs				
Evictions	20	4	10.6**	.254
Loss of property to pawnshops/banks	24	3	16.2**	.314
Cashing in investments	3	20	10.3	.250
Health & Self-Care				
Not taking care of myself	30	18	3.7*	.149
Problems with appetite	29	8	12.2**	.271
Physical problems	28	12	6.8**	.204
Relationships				
Time away from friends/family	29	14	6.0*	.190
Missing family functions	17	7	4.0*	.156

* $p < .05$. ** $p < .01$.

Another group of items relates to health and self-care**.** Bingo players more often identified *not taking care of myself* (30% vs. 18%), *problems with appetite* (29%

vs. 8%) and *physical problems* (28% vs. 12%). Bingo players also identified weight management more often than did the slot players, adding to the impression of increased health issues. Specific to relationship impacts, bingo players were more likely than the slot players to identify *time away from friends or family* (29% vs. 14%) and *missing family functions* (17% vs. 7%).

The health concerns identified by the bingo players are similar to those of older women who played bingo in the study by O'Brien Cousins and Witcher (2007) that bingo players were more sedentary with more physical health limitations than the non-bingo players. They found an inverse relationship between activity levels and gambling expenditures; physical inactivity was the only significant determinant of money spent on bingo. While the bingo players in this sample were younger than the sample of O'Brien Cousins and Witcher (2007), the finding suggest the possibility that further research would reveal a more passive lifestyle among bingo players generally. Based on the number of younger bingo players in this sample who are on a disability, who have considerable histories of abuse and trauma and serious levels of mental health issues, passive pursuits may be more typical of problem bingo players.

Treatment Considerations

Barriers to Treatment

Most of the bingo and slots players in this sample were gambling at pathological levels. About half of the women had thought about or tried to make changes but few (16% of the bingo players, n=11, 17% of the slot players, n= 16) had ever been involved in gambling specific treatment or Gamblers Anonymous. The questionnaire explored the barriers to treatment, providing the women with an extensive list (over 80 items) and asking them to indicate whether each item constituted a personal barrier.

Overall, the barriers to treatment were most often psychological, with practical concerns being identified by less than 30% of the women. The chief practical barrier was time constraints for 62% of the bingo and 66% of the slot players. The most common barriers are included in Table 16. The groups were very similar. Part of the reluctance to seek treatment appeared to be related to a wish to continue gambling. The majority hope for a "big win" to resolve problems. Gambling offers hope that things can improve in their lives. Many identified a lack of information about treatment, not knowing of services or what to expect. The women identified concerns

that a treatment program would require them to stop all gambling. Self-reliance was also a barrier. Many women believed they could and should make changes on their own. Over a third indicated that asking for help would be an admission that they cannot control the behaviour.

Table 16.
Barriers to Treatment for Bingo and Slot Players

Key Barriers to Treatment	Bingo (*n*=69) %	Slot (*n*=96) %	χ^2	ϕ
Gambling Related Barriers				
Keep hoping for *Big Win* to resolve problems	71	51	6.6**	-.201
Gambling gives me hope things can improve in my life	41	39	.1	-.021
Love to gamble	22	41	6.2*	.195
Beliefs about Change & Treatment				
Think should be able to makes change on my own	68	73	.4	.052
Believe would have to give up gambling	65	57	1.1	-.080
Don’t know of available services	49	33	4.3*	-.161
Services are only for women with very serious problems	45	52	.8	.071
Don’t know what to expect from treatment	42	34	1.0	-.079
Fear I might be recognized	12	25	4.6*	.167
Personal Barriers				
Embarrassment & shame about gambling	42	30	2.4	-.122
Asking for help would be admitting I’m unable to control my gambling	36	37	.0	.002
Other problems more important than my gambling	36	17	8.2**	-.223
Practical Barriers				
Time constraints	62	66	.2	.034
Depression	29	14	6.0*	-.190
Transportation costs	23	9	10.0*	-.190
Lack of transportation	22	8	6.0*	-.191

** p < .05. ** p < .01.*

Looking at significant differences in barriers to treatment, slot players were more likely to indicate that they *love to gamble***.** On the other hand, bingo players were more likely to be *hoping for a big win*. Although both bingo and slots players were worried about being criticized or judged, twice as many slot players as bingo players indicated concerns about being recognized Consistent with their more limited finances, the bingo players reported barriers of transportation almost three times as often as the slot players. In concert with their personal struggles with mental health issues, the bingo players reported barriers of *depression* twice as often as slot players. Not surprisingly given the number of mental health and addiction concerns identified by the bingo players, they were also more likely to indicate that other problems in their lives were more pressing than the gambling.

Treatment Needs

In an exploration of treatment service needs, participants were asked to rate on a 4-point Likert-type scale (1=*not helpful*, 2=*somewhat helpful*, 3=*very helpful*, 4=*extremely helpfu*l) a number of options drawn from the best practices literature for treatment of women's addiction (Allen, 2003; Currie, 2001; Gordon, 2002). For this analysis, the data were collapsed into two categories by combining 1 and 2, 3 and 4. The options followed a "stepped-care" approach (care adjusted in stages according to the failure or lack of effect of lower intensity interventions) of increasing intensity, ranging from information to intensive residential programming. Key findings related to direct service counselling treatment needs are reported in Table 17.

Table 17
Direct Service Treatment Counselling Needs for Bingo and Slot Players

Counselling Treatment Needs (Very or Extremely Helpful)	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Individual Counselling	61	64	.1	.026
Location				
Gambling treatment centre	67	66	.0	.004
Women's centre	67	62	.3	.046
Medical centre	62	50	2.0	.159
Mental health centre	61	44	3.9*	.167
Group Counselling				
Women's group	58	52	.6	.060
Co-ed group	21	38	5.8*	.189
Phone Counselling	58	59	.0	.005
Crisis Counselling Access	48	51	.2	.033
24 hours	70	77	.9	.081
By phone	67	70	.2	.038
At place I gamble	33	51	4.1*	.179
Couple Counselling	52	43	.9	.088
Family Counselling	43	29	.3	.142
Intensive Treatment	55	55	.0	.003
Residential	27	17	2.2	.127
Out patient	31	47	2.2	.138

* $p < .05$. ** $p < .01$.

Individual counselling was highly endorsed as very or extremely helpful by both groups. *Group counselling* was valued by over half of the women, but bingo players were more likely to prefer a women's group, and selected this almost three times as often as a mixed or co-ed group (58% compared to 21%). Specific to the location of services, the women preferred a women's centre or gambling treatment centre. The bingo players were more likely than the slot players to suggest that treatment be available at a mental health centre (61% vs. 44%).

The options of *phone counselling* and *crisis counselling* available 24 hours a day were thought equally helpful by a majority of the women. The slot players were

more likely than the bingo players to suggest crisis counselling be available *at the place I gamble* (*51% vs. 33*%), perhaps confirming the rapid escalation of financial stress and loss of control related to machine gambling. *Family counselling* and *couple counseling* were highly valued by about half of the respondents. Intensive residential or outpatient programs were thought helpful by less than a third of respondents.

Treatment Content

The issues that the women thought would be *very or extremely helpful* to address in treatment were explored by considering 10 groups of items:

1. Making changes to gambling (8 items)
2. Financial survival (7 items)
3. Personal enrichment (12 items)
4. Leisure and social skills (3 items)
5. Relationship issues (9 items)
6. Parenting issues (2 items)
7. Social oppression (6 items)
8. My body and food (3 items)
9. Life changes (7 items)
10. Dealing with the system (5 items)

Although all areas were thought helpful by many of the women, differences between the bingo and slot players emerged on 32 of the 62 items. The priorities of the bingo and slots players differed. Whereas key items for the bingo players were in the area of *Personal Enrichment*, key items for the slot players emerged in the area of *Making Changes to Gambling*. The findings are shown in Table 18.

Table 18
Treatment Content for Bingo and Slot Players: Personal Enrichment

Treatment Content :Personal Enrichment (Very or Extremely Helpful)	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Self-esteem	85	53	18.4**	.337
Stress	81	71	2.1	.114
Depression	79	55	9.5**	.243
Empowering myself	72	46	10.7**	.258
Anxiety	72	54	5.0*	.176
Guilt/shame	61	48	2.8	.132
Spiritual well-being	59	53	.6	.063
Burnout	51	45	.5	.056
Perfectionism	39	47	.9	.076
Chronic pain	49	31	5.3*	.186
Excessive drinking	28	13	7.3**	.224
Drug use	23	12	4.9*	.187

* $p < .05$. ** $p < .01$.

Personal Enrichment

Bingo players chose multiple issues in the area of personal enrichment significantly more often than did the slot players. *Self-esteem* was the chief concern of the bingo players, (83% vs. 52% by the slot players). Other areas selected more often validate the earlier findings of higher levels of health issues and co-occurring problem behaviours among the bingo players: *Depression, Anxiety, Chronic Pain, Empowerment*, *Excessive Drinking* and *Drug use*.

Financial Survival

The second cluster of items that were reported as very or extremely helpful by bingo players related to financial survival. As shown in Table 19, *ways to increase income* was the item most frequently endorsed as helpful (83%). Issues related to *money values*, *money management, upgrading education, employment* and *resolving couple conflicts* over money were also identified as helpful more often by the bingo than slot players.

Table 19
Treatment Content for Bingo and Slot Players: Financial Survival and Leisure

Treatment Content (Very or extremely helpful)	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Financial Survival				
Creative ways to increase income	83	67	5.5*	.186
Money values	73	56	4.8*	.170
Money management	70	60	1.6	.098
Resolving debts	65	57	1.2	.085
Upgrading education	59	34	9.4**	.247
Employment training	53	21	17.0**	.336
Couples & money	47	29	5.5*	.188
Leisure and Social issues				
Meaningful use of my free time	77	71	.8	.070
Having fun	75	72	.1	.027
Dealing with isolation and loneliness	67	45	7.6**	.217

* $p < .05$. ** $p < .01$.

Leisure and Social Issues

The third cluster of items important to bingo players, also shown in Table 19, related to leisure issues. Almost three quarters of both groups identified the *use of free time* and *having fun* as very of extremely helpful issues to address in treatment. The bingo players, however, were more likely than the slot players to select the topic of *dealing with isolation and loneliness* (65% vs. 45%).

Making Changes to Gambling

A focus on making changes to gambling is the fourth group of items most frequently selected by the bingo players; stopping the gambling behaviours, learning about triggers and dealing with urges were the items in this area thought most helpful. It is of some interest that dealing with social pressure was a low priority for both groups, likely related to the tendency for gambling to become an asocial activity as problems develop.

As is apparent from Table 20, the only item distinguishing the bingo players was that of *getting support from family and friends*; almost twice as many bingo as slot players identified this as very or extremely helpful (57% vs.30%). Perhaps relevant in understanding this is a finding that 45% of bingo players in relationships reported having partners with drugs or alcohol problems and 50% reported was abuse in the relationship. As with women's experience of recovery from other addictions, a lack of spousal support is often an issue for female problem gamblers (Canale, 1996; Currie, 2001; Gordon, 2002; Lesieur & Blume, 1991).

Table 20
Treatment Content for Bingo and Slot Players: Making Changes to Gambling

Treatment Content: Making Changes to Gambling (Very or Extremely Helpful)	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
Strategies to stop gambling	71	66	.4	.050
Learning about triggers	67	70	.2	.038
Coping with urges	65	72	.8	.068
Strategies to limit gambling	65	70	.5	.056
Getting support from family and friends	57	30	10.8**	.257
False beliefs:how to win	52	50	.1	.027
Mathematical odds	51	40	1.9	.107
Dealing with social pressure	29	24	.5	.054

* $p < .05$. ** $p < .01$.

Other Differences

The exploration of the primary treatment issues helpful for the bingo and slot players provided a clear sense that their treatment needs are quite distinct. This was confirmed by items from other categories that distinguished the bingo from the slot players. As not all items were applicable for all respondents (e.g., menopause, housing, dealing with Workfare, empty nest, excessive drinking), only key items are compared, and the number of respondents to each item is indicated (Table 21).

Table 21
Treatment Content for Bingo and Slot Players: Other Issues

Treatment Content :Other Differences (Very or extremely helpful)	Bingo (n=69) %	Slot (n=96) %	χ^2	ϕ
My Body & Food				
Weight Management (n=157)	70	50	6.4*	.202
Relationships				
Anger (n=158)	66	43	8.1**	.226
Assertiveness (n=158)	64	44	6.3*	.200
Conflict (n=156)	59	36	7.5**	.220
Powerlessness (n=149)	53	30	7.5**	.231
Spousal Violence/Abuse (n=146)	49	25	9.4**	.253
Sexuality (n=150)	47	22	10.6**	.266
Spousal addiction (n=144)	45	25	6.3*	.209
Life Changes				
Grief (n=157)	59	53	.6	.063
Trauma (n=156)	60	45	3.4	.066
Oppression				
Violence & abuse in my life (n=136)	49	27	6.8**	.224
Parenting				
Parenting skills (n=121)	56	29	8.8**	.270
Coping as a single parent (n=157)	51	29	5.9*	.226
Dealing with the System				
Housing (n=131)	45	24	6.2*	.217
Workfare/Disability (n=128)	37	22	3.7*	.169
Criminal justice system (n=121)	27	13	3.9*	.179

* $p < .05$. ** $p < .01$.

It is worth noting that half of both groups identified dealing with *grief* and *trauma* as helpful. The difference between the groups on the issue of trauma was on

the margin of being significant. Items of special importance to the bingo players are congruent with their socio-economic status, histories of abuse, mental health concerns and struggles with other problematic behaviours. The bingo players selected a number of relationship issues more often, asking for support in dealing with anger and conflict, dealing with partner violence and addiction, and sexuality. Issues related to parenting and dealing with practical matters such as housing, *Workfare* (a welfare program) or disability programs also emerged more often for bingo players.

The bingo players (27%) were also more likely to select *dealing with the criminal justice system* as a helpful issue but it is not clear whether there is a casual relationship between their gambling and criminal activity. Bingo players did report higher past incidences of shoplifting and criminal behaviour than those reported by the slot players (see Table 8). Among the drawbacks to gambling a few bingo players reported *stealing money* (9%), *writing bad cheques* (7%), *criminal charges* (4%) and *jail time* (1%) as often or always drawbacks.

These findings are somewhat unusual in light of the research exploring the relationship of problem gambling and crime. Some problem gamblers turn to crime to support their gambling habits once legal sources of funds are exhausted. The costs to society of arrest, prosecution and incarceration of people arrested for gambling-related offences are high (National Council of Welfare, 1996). Research reports on gamblers in treatment and Gamblers Anonymous (GA) indicate that 21% to 85% of the gamblers admit to criminal activity to finance the gambling or deal with gambling related debts (Abbott, 2002; Blaszczynski, 1996; Lesieur, 1993; Lesieur & Blume, 1991; Westphal & Johnson, 2000); from 4% to 13% serve custodial time. Female problem gamblers are more likely than male problem gamblers to engage in crime to support their gambling, but the crimes are less serious and less likely to be violent. Women are more likely to be convicted for gambling related offences than are men (Abbot, 2002; Westphal & Johnson, 2000). Over half of the women problem gamblers in two North American studies admitted to criminal activity to finance the gambling; 20% of the women were arrested (Lesieur, 1993; Westphal & Johnson, 2000).

Given the above, admissions of criminal activity and legal consequences related to gambling by the women in this study appear to be low. The fact that this is not a treatment sample may provide a partial explanation in that those who have

openly acknowledged the gambling problem may also be more open about the gambling related behaviours. The study format of a written questionnaire may also have created some discomfort about admitting to criminal activity.

Prevention and Outreach for Bingo Players

The women's thoughts about preventing problem gambling were explored with 41 items related to *community education*, *changes to gaming establishments*, *self-exclusion* and *venue initiated interventions*. The focus in this brief section is on the input from the bingo players on prevention and outreach.

As noted, one of the obstacles to treatment identified more often by the bingo players was a lack of awareness of available treatment services. This may be due in part to the fact that the racetracks and casinos have signage promoting the Ontario Problem Gambling Helpline (OPGH) whereas the bingo halls do not. Many of the bingo players (94%) recommended *more public information on available supports*; they also endorsed *increased advertising about the risks and problems of gambling* as important prevention initiatives (88%)

The relevance of these results is underscored by bingo players' input on seeking help. Most (80%) would look for written materials. Almost half (45%) would talk with a friend. These results are similar to the findings of Schellinck and Schrans (1997-1998), in a Nova Scotia study that gamblers are more likely to seek help from informal sources and tend to access family and friends twice as often as outside sources. Thus educating the general public, friends and family, is critical to prevention and outreach.

Key Professionals and Bingo Players

Related to help seeking, half (51%) of the bingo players indicated that they would seek professional help: 42% would speak to their family doctor and 33% would access a mental health centre. This is consistent with literature reporting that women are more likely to access such services than seek addiction specific treatment. Women are "more likely than men to mistake the symptoms of addiction for psychiatric or medical problems or as a response to stress" (Gordon, 2004, p.14). It can be difficult to identify whether the mental health issues are primary, secondary or bi-directional. Depression and anxiety, for example, can be a cause or a result of the gambling, and cannot readily be diagnosed in problem gamblers as the symptoms can abate when the behaviours ceases.

As a group the bingo players in this study present information suggesting that they are often depressed and overwhelmed. A large proportion (36%) indicated that other problems are more important than the gambling. Based on the findings, outreach needs to include professionals such as doctors, mental health or social workers who may encounter these players. Educating these professionals to detect problem gambling is crucially important.

Natural Recovery

The reality is that most of these women will never seek treatment. Self-change is the most common route of recovery; only 4% of problem gamblers ever attend programs (Hodgins, 2000; Marotta, 2000). Schellinck and Schrans (1997-1998) argue that effective intervention programs and strategies must be designed to target specific types of gamblers "as it is highly unlikely that the majority of those experiencing difficulties will be initiating contact with formalized treatment providers" (p. 19). For those who will make changes on their own, the provision of indirect support is important.

Support can take different forms. The bingo players suggested that prevention include *women sensitive information materials* (bingo 84%). They also identified the following as very or extremely helpful: *internet information about gambling* (42%), *internet self-help chat room* (42%) *self-help manual* (40%), *audio tapes or video* (36%) and *computer program* to help with gambling problems (30%).

One indirect form of support urged by the women echoes the concerns made by Dixey (1987) and others about the social constraints which shape and limit women's leisure options. Finding a substitute that is fun, accessible, affordable and safe is often the most recalcitrant recovery issue for female bingo players: Most cannot afford to join gyms, golf clubs or travel, have physical limitations or mental health difficulties such as depression or anxiety (Boughton, 2003). Most of the bingo players (75%) in this sample recommended the *provision and promotion of alternative leisure activities*; 78% also endorsed *the provision of a women's centre for health promotion* as helpful to preventing problems.

Summary of Key Findings

The forgoing analysis has compared a group of female bingo players with a group of female slot machine players on a number of dimensions. Specific to demographic profiles, the bingo players were significantly younger. The two groups

were similar in marital status and general employment status; over 40% of both groups were married and about half were employed. However, the unemployed bingo players were more likely to be on a disability pension. They also showed significant socio-economic disadvantages in being less well educated and having lower personal and family incomes.

The women reported playing similar numbers of different games, such as scratch or lottery tickets, cards or horses. Access to gambling venues determined playing patterns for the slot players more than for the bingo players. Slot players were more likely to travel two hours to access the venue, and more likely to play all night.

On the surface bingo players appear to have fewer negative financial consequences to their gambling. They play more often per month than do the slot players but spend less money per month gambling and a smaller percentage of their personal incomes. Their average gambling related debt is also lower. The reality, however, is that there is likely a more powerful impact of excessive spending for bingo players because of lower incomes.

The problem gambling measure (South Oaks Gambling Screen) suggested that the majority of both groups of players were probable pathological gamblers.

It is in the arena of personal and family history that the differences between the groups are most remarkable. The bingo players seemed to be more vulnerable and seemingly less resilient in dealing with stress. The family history of the bingo players suggests intergenerational problems. They were more likely to have a mother with a drug problem or a relative with a gambling problem. They also reported experiencing abuse, both as children and adults, significantly more often than did the slot players, at levels higher than those found in the general population. Bingo players reported more co-occurring problems with smoking, the abuse of non-prescription drugs and compulsive shopping than did the slot players. They also reported past problems with alcohol abuse, abuse of prescription drugs, shoplifting, eating disorders and criminal activities twice as often as the slot players. Adding to a sense of the severity of the issue, bingo players were more likely to indicate suicidal behaviours. Half of the bingo players, twice as many bingo players as slot players, had attempted suicide.

Specific to the attraction of gambling, it often appears for the bingo players to be a means of coping with considerable life stressors related to both relationships and finances. They are more likely to endorse reasons related to emotional coping or

reasons indicative of strained relationships, including gambling as a reaction to the drinking or drug use of partners.

The drawbacks to gambling reported by the bingo players issued from their disadvantaged socio-economic status and included threats of eviction and sale of items to pawnshops. In contrast, the financial consequences for slot players included cashing in investments. Bingo players more often identified drawbacks related to health, such as problems with appetite, weight management, physical problems and lack of self-care.

Barriers to treatment were more psychological and emotional than practical. Gambling lures and benefits created barriers for the bingo players at higher frequencies than for the slot players. Many hoped for the big win to resolve problems or improve their lives. Most of these women did not want to stop gambling. A second major barrier was that of self-reliance, perhaps a mixture of ambivalence and shame, thinking they should be able to make changes on their own. Information gaps about treatment were a third barrier. A large proportion of the bingo players were not aware of services. They believed that they would be required to stop all gambling, apparently not aware that the Ontario treatment system uses a harm minimization approach.

Bingo players emerged as distinct in their treatment needs. The findings were similar in terms of practical aspects of treatment, with both groups of women indicating that individual and group counselling would be helpful. The bingo players placed a stronger emphasis on women's groups and were more likely to suggest that treatment be available at a mental health service. They evidenced different priorities and needs around treatment content, proving to be less focused on making changes to the gambling and more focused on personal and practical concerns such as self-esteem, disempowerment, financial stress, abuse, addiction and relationships. On the other hand, with the exception of stress (71%) the most frequently selected needs of the slot players lay in the category of making changes to the gambling.

The women's advice on prevention underscores the need to develop outreach and prevention initiatives tailored to the unique needs of players. Most bingo players suggested more public information on available supports and increased advertising about the risks of gambling. Their input also confirms that outreach needs to include education of the public and of professionals such as social workers, mental health care

workers and doctors. These professionals are more likely to first encounter the bingo players, who may be presenting for problems other than gambling. Indirect supports for those who will make changes on their own include information, self-help manuals and Internet resources. The women also strongly recommended the provision of facilities to meet their leisure and social needs.

CHAPTER 5. CONCLUSION

As indicated in our review of the literature, a few studies that focus on the game of bingo and the players do so from social, leisure and health perspectives. A few feminist qualitative studies explore the bingo culture and the meaning it holds for players. Others look at bingo as a game played by populations of older adults. The general consensus from these researchers is that bingo offers social and leisure benefits to many of the players. Bingo halls (and casinos) offer women a measure of safety, comfort and accessibility not readily available elsewhere. Although research on problem bingo play is limited there are, “hints of deviance” reported in some players.

With the exception of a groundbreaking study by Wynne in Alberta (1994), this study is the only known study to compare women bingo and slot players in the general population and to focus specifically on problematic bingo play. The study makes clear the existence of significant differences between women who play bingo and women who play electronic gaming machines at a problematic level.

To begin with the analysis suggests that the differences between the women’s patterns of gambling and choice of games are primarily related and socio-economic status and to proximity to venues. The game characteristics of bingo and slot play appear to be less critical than the demographic differences between the players. This is consistent with literature noting the association of certain forms of gambling with different socio-economic classes (Dixey, 1987; Oliveira & Silva, 2001; Walker, 1992). While a future study considering psychological differences might identify whether internal factors (i.e., extraversion, self-esteem, personality, impulsivity, see Steele and Blaszczynski, 1998) play a role in choice of game, the findings in this study point to the socio-economic variables and correlates as key.

A second, related, overarching finding is the differences between the women specific to personal and family histories. The bingo players report consistently higher levels of mental health, abuse, addiction, behavioural and relationship issues. Three observations are relevant to understanding the interplay of issues reported by the bingo players. First is the association of poverty and violence. Statistics Canada (2006) report that socio-economic factors such as low income are linked to higher rates of spousal assault against women: rates of spousal assault in 2004 were twice as

high for women with a household income of less than $60,000 compared with those with higher incomes. The report adds:

> It is unclear whether low income is a risk factor, a consequence of violence or a combination of both. The stresses associated with living in low-income situations may lead to frustration and tension in the family and to the use of violence as a response. Alternatively, violence may lead to separation which results in a reduction of income for both victim and offender in subsequent relationships. Steady employment also may be affected by injury, contacts with the criminal justice system, or other negative consequences of spousal violence. Lack of resources may also be a factor in preventing women from leaving violent relationships. (p. 40).

The second factor relates to poverty and mental health. The Canadian Mental Health Association (CMHA) (Zoutris, 1999, p. 23) reports that depression levels are significantly higher for Ontario residents raised in *Blue Collar* families compared to *White Collar* families (9% vs. 6%).

The third observation is the high correlation between sexual abuse and mental illness. A history of abuse in childhood increases the likelihood of lifetime psychopathology, an association that appears stronger for women than men (MacMillan, Fleming, Streiner, Lin, Boyle, Jamieson, Duku, Walsh, Wong & Beardslee, 2001).

Thus economic conditions and high levels of abuse contribute to mental health concerns, which in turn factor into the high levels of both addiction and suicidal behaviours reported by the bingo players. As noted, Newman and Thompson (2007) found that the "sex" was not associated with attempted suicide by problem gamblers, suggesting that the increased rate of attempted suicide among women may be largely owing to their greater prevalence of depression. Blaszczynski and MacCallum (2003) also noted that those gamblers reporting suicidal ideation were more likely to be depressed than non-suicidal pathological gamblers but did not report more gambling problems.

In short, the combination of these facts suggests that the problematic bingo may not be the key issue in the lives of these troubled players. As many of the bingo players in this study indicated, "Other problems are more important than my gambling".

Existing research suggests that women gamblers generally require specialized treatment approaches (Crisp, Thomas, Jackson, Thomason, Smith, Borrell, Ho & Holt, 2000; Petry, 2002; Thomas & Moore, 2003). These findings lend weight to an

argument that differences in game choices also need to be considered as part of designing interventions to help problem gamblers. This is consistent with the suggestion by Schellinck and Schrans (1997-1998) based on a Nova Scotia study that gamblers are not a homogenous group, that the game being played is important in drafting prevention and treatment initiatives. However, the caveat is that the characteristics of the actual games may be less important than attending to the underlying life circumstances that may facilitate the gambling behaviour. This is consistent with the suggestion by Thomas and Moore (2003) that some therapies focus too narrowly on overt gambling behaviours or cognitions and too little on underlying factors (p. 19).

The findings suggest that, to be optimal, treatment must address not only the gambling behaviours but also the underlying stressors and practical needs of the women. It needs to be holistic and offer a broad range of services. Bingo players may need more assistance with such practical concerns as employment or educational upgrading. Dealing with financial stress often requires different interventions for bingo players, who may have limited skills in budgeting (including setting limits on the gambling expenditures) and be unaware of options such as Credit Counselling Services or bankruptcy. They may also require more assistance addressing mental health issues and other concurrent issues such as drug use or drinking. The task of finding alternative leisure or social options that are safe, affordable and accessible is complicated by financial restrictions.

The diversity and intensity of the underlying issues of the bingo players underscores the importance of screening**,** with special attention to psychiatric co-morbidity, eating disturbances, use of prescribed medications, compulsive spending and abuse. It also underscores the importance of facilitating easy and timely access to the services of other professionals for consultation and/or referral. Unfortunately this is a major challenge in our current medical and social services system. Given that problem gambling may be a secondary issue for many problem bingo players, educating professionals and embedding gambling counsellors in other programs working with women is also important.

This study has limitations. The non-random sample and limited representation from diverse ethnocultural groups of women across Ontario means that the findings

cannot be generalized to all female bingo players. The absence of male bingo and slot players means that no gender comparisons can be made.

The findings do, however, alert us to the possibility that women who play bingo may have treatment needs and issues that are qualitatively different from other women problem gamblers. It also underscores the need for expanded prevention, outreach and treatment interventions geared specifically to women who belong to underprivileged, impoverished and often-marginalized social groups. In Ontario these women are often playing bingo; in other cultures they may be playing different games (such as housie played by the Maori women of New Zealand or the Electronic Gaming Machines played by women in Australia).

One final clinical observation and socio-political concern emerges from these findings. This study suggests a heightened vulnerability, presumably more dysfunctional coping skills and more limited financial resources of many women bingo players as compared to women slot players. Over the past few years the number of bingo halls in Ontario has been dramatically reduced (from over 200 in the year 2000 to approximately 70 as of 2008, while the number of slot machines has increased. Ontario now has 4 commercial casinos (3 in cities near the border with the USA and 1 on an Indian reserve), 6 charity casinos and 17 racetracks (with slot machines).

The decline is related to the ban of smoking in bingo halls, the rapid expansion of Ontario venues offering slot machine play and the increased ease of accessibility. Promotional efforts to attract players include numerous incentives and free transportation, and women and seniors are specifically targeted. Bingo players appear to be migrating to slot play. Clinicians at the Problem Gambling Service of CAMH currently encounter fewer women identifying bingo as the problematic game and increasing numbers who report switching to slot play, rapidly escalating into financial crisis as a result. A researcher for the Drug and Alcohol Treatment Information System (DATIS) confirms this decline in the number of bingo players among treatment seeking populations of Ontario. Bingo was played by 18% of the women seeking treatment between 2003 and 2005, compared to 46% in 2001 (personal communication with B. Rush, DATIS, August, 2007).

Bingo offers some women social and leisure outlets not otherwise available. It often serves as a coping mechanism for stress and a break from overwhelming

caretaking demands or relationship struggles. It allows respite and distraction from mental health and physical problems. The women seeking treatment services at CAMH are reporting increased loneliness, as slot play tends to be more secretive and isolated. From the perspective of a harm reduction model bingo has more natural constraints that serve as protective factors than do slot machines. Thus the closures of bingo halls across Ontario could be considered unfortunate. Adding to the complexity of the issue, however, are the countermoves launched by the Ontario Lottery and Gaming Corporation (OLGC). As the bingo industry is threatened by the increasing numbers of slot machines being introduced to racetracks across Ontario, the OLGC is attempting to help bingo operators become more competitive with other forms of gambling. They now offer large prize amounts through Province-wide electronically linked games. In January of 2005 they initiated a *bingo revitalization project* as part of the provincial government's gaming strategy and began conducting pilot studies with electronic bingo games to give players the option of playing games through computer terminals. In short, they are giving bingo players the opportunity to spend faster. With fewer resources to cope with the consequences of problematic levels of play, the group of women who play bingo, already suffering the effects of poverty, marginalization and mental health challenges, are at greater risk for becoming problem gamblers. The social costs of problem gambling are bound to increase. This raises a public health consideration. This is a concern that needs to be taken seriously by those responsible for the health and welfare of Ontario citizens challenged by poverty and mental health issues.

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