Mindfulness in Women Who Gamble

Summary Report for the Manitoba Gambling Research Program

Principal Investigators:
Tracie Afifi, PhD, University of Manitoba
Martin Zack, PhD, Centre for Addiction and Mental Health (CAMH)

Co-Investigators:
Shelley McMain, PhD, CAMH
Daniela Lobo, MD, PhD, CAMH

Funding:
Small Grant ($49,999)

Research Priority:
Examine which types of at-risk and problem gamblers could benefit from various brief interventions.

Significance

Between 3 and 5% of adults in Canada have problems with gambling severe enough to warrant a formal diagnosis of Gambling Disorder (GD). People with GD experience profound disturbances in their day-to-day functioning including social, occupational, legal and psychological problems. Suicide rates are also very high in people with GD. A number of treatments have been developed for GD, which incorporate strategies similar to those used to manage substance addiction. Research suggests that many people who undergo therapy that helps them change their thoughts and behaviour around gambling can achieve long-term abstinence. However, these therapies do not work for everyone. In addition, people with a history of GD may relapse to gambling even after long periods of abstinence, especially when they experience intense distress. People who gamble as a way to cope with distress and those who have experienced childhood neglect or abuse are especially prone to this pattern. This pattern is also more common in women with GD, who tend to experience more anxiety and depression, compared to men with GD. In recent years, therapies have emerged that aim to help people tolerate intense negative emotions and to refrain from acting impulsively or self-destructively when they occur. Mindfulness-based interventions (MBIs) are one example of this type of therapy. Derived from a form of Buddhist Yoga, MBIs encourage individuals to observe their thoughts and feelings without trying to get rid of them or blaming themselves for having them. People who undergo MBIs learn a form of meditation where they focus their attention on current experience (e.g., breathing) as well as any thoughts or feelings that may come to mind. Through daily meditation, MBIs can help the person learn to 'ride out' intense emotions. Given their success in treating depression and substance abuse, we reasoned that MBIs may help women with GD become more compassionate (i.e., 'mindful') towards themselves and increase their ability to tolerate intense emotions rather than resorting to gambling. To see if women who seek treatment for GD are distinctive in their profile of risk factors (e.g., childhood maltreatment), we administered the same questionnaires to a separate group of non-treatment-seeking female gamblers who answered them on-line.

Research Questions

1. Do treatment-seeking women with GD differ from female gamblers in general?
2. Does undergoing MBI reduce gambling symptoms in women with GD?
3. Is the benefit of MBI related to an increase in mindful attitudes or distress tolerance?

Methodology

Nine women with GD (average age 56.2) attended 10 weekly group MBI therapy sessions (in 3 separate groups) and practiced mindful meditation between sessions. They were evaluated before, during and after treatment, and kept diaries to record their mood and urges to gamble between treatment sessions. Twenty female gamblers from the general community (average age 42.3) completed the same background questionnaires as the treatment group.

Key Findings

Women in the MBI sample displayed an overall pattern of increased psychological problems and difficulties in functioning on almost every questionnaire compared to the community-based sample. Unexpectedly, however, self-reported mindful attitudes (e.g., conscious awareness of the present moment) and tolerance for distress were quite similar in the two samples. The treatment sample spent an average of $6903 gambling over the preceding 3 months, compared to an average of $2278 in the community sample. The severity of GD symptoms in the treatment group was comparable to the average severity of people seeking treatment for gambling problems. Overall gambling symptoms in the community sample were below the threshold for GD. Women in the MBI sample were more likely to gamble to enhance positive moods and cope with negative moods than women in the community sample. Women in the MBI sample also reported more inaccurate beliefs about gambling (e.g., the belief that continuing to gamble is a good way to win back losses).

Personality scales indicated greater extraversion (sensation-seeking, risk-taking), greater neuroticism (emotional instability) and greater impulsivity (acting without thinking, acting in response to urges) in the MBI sample. Clinical scales indicated greater levels of depression and problems putting feelings into words in the MBI vs. the community sample, although the two samples did not differ in their levels of anxiety. Of particular relevance were the results for scales assessing Parental Bonding and Childhood Exposure to Violence. Women in the MBI sample reported higher levels of over-control and lower levels of emotional support for both mother and father, along with greater exposure to violence, than did women in the community sample. The elevation in scores for the MBI sample was at least three-fold that of the community sample on every aspect of childhood maltreatment.

Among women in the MBI sample overall severity of GD symptoms declined by approximately 28% over the course of treatment. The change although modest, was statistically improbable based on chance alone. Furthermore, no appreciable change in symptoms was seen during the interval between enrollment and the start of treatment or during the time from completion to follow-up, suggesting that the decline during treatment was not due solely to the passage of time. Ratings of 'craving' or urge to gamble for the days between MBI sessions also declined over the course of treatment, in this case by approximately 23%. This change was also unlikely to have occurred by chance alone. Along with the change in GD symptoms and motivation, the sample displayed a 20% decrease in depressive symptoms, which was also statistically improbable by chance alone. Lastly, the sample paid more consistent attention to negative emotional words (e.g., ashamed) displayed on a computer task at post-treatment relative to pre-treatment. Together with the decline in depression scores, this latter result may reflect enhanced tolerance for involuntary negative thoughts.

Conclusions and Implications

The study was limited by the very modest size of the samples and corresponding inability to examine the relationship between therapeutic response, mindful attitudes and background characteristics, like childhood maltreatment and/or distress tolerance that may contribute to GD. MBI coincided with a modest but reliable decline in GD severity, gambling urges and depression and increase in attention to negative emotional stimuli in women with GD. Whether these benefits are specifically due to MBI as opposed to the benefits of support from a therapist or other group members remains to be determined. These initial favourable results warrant future investigation in a larger study designed to compare group-based support (e.g., Gamblers Anonymous) with group-based MBI in a sample comprised of both men and women with GD. Such a study would enable us to directly assess gender differences in the effects of MBI and along with the relationship between background factors like childhood maltreatment, distress tolerance and the degree of benefit from MBI.

This research was funded by the Manitoba Gambling Research Program of Manitoba Liquor & Lotteries; however, the findings and conclusions of this paper are those solely of the author(s) and do not necessarily represent the views of Manitoba Liquor & Lotteries.