Switching the Lens: Using a Relational Stance to See Beyond the Disorder

Anna Kaufman

Portfolio submitted in fulfilment of the requirements for the Professional Doctorate in Psychology (DPsych)

City University

Department of Psychology

School of Arts and Social Sciences

September 2015

THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS:

pp. 182-183: **Appendix O.** Extracts from reflective diary.
pp. 185-214: **Section B.** Case study: Developing a relational approach.

THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT REASONS:

pp. 217-230: **Section C.** Publishable paper: Barriers to treatment for female problem gamblers.

Table of Contents

Acknowledgements

To my research supervisor, Jessica, I would like to say thank you for all your support, guidance, enthusiasm, energy and inspiration over the past two years. You have kept me going up until the bitter-sweet end.

To the participants who agreed to take part in this study, thank you for sharing your time, experiences and selves. This study would not have been possible without you and I hope the final product goes some way towards making your voices heard.

To the wonderful team at the [redacted] in which my research took place, I am thankful to you for your support and expertise.

To my husband, Saul, your patience, understanding and kindness over the past three years (and beyond) has been unfaltering. Thank you for believing in me; without your support, I could not have made this journey. To Lucy, you have been a guiding light throughout, thank you.

To my beloved friends and family, who often wondered where on earth I have disappeared to these past few years. I'm back!

This portfolio is dedicated to all of you.

Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Preface

This thesis is primarily concerned with aspects of theory and practice in Counselling Psychology, with a focus on the issue of 'interpersonal relationships' which I believe underscores the entire portfolio. It seeks to demonstrate the depth and breadth of clinical and research skills I have acquired over the past three years as I have embraced my identity as an evidence-based practitioner. I will begin by outlining the three components of the portfolio, and will move on to discuss the evolution and development of it as well as the main threads which weave throughout each section. I will conclude by reflecting on professional issues which I have become aware of through the process of writing the thesis, alongside the clinical and academic demands of training.

Section A: Doctoral Research

The Doctoral Research is the chief component comprising this portfolio, in which I explore the lived experience of treatment for female problem gamblers through my lens as a researcher. In an attempt to understand what it is like to experience this phenomenon, I have conducted an Interpretative Phenomenological Analysis of eight individuals' experience of treatment. The findings yield fruitful and invaluable insights into individuals' perspectives, including motivating factors, barriers to treatment and positive and negative aspects of their therapeutic journey. A compelling relational dimension emerged from the women's accounts and their experiences were found to be fundamentally grounded by their experiences of relationships. This supports the notion that more attention should be paid to the interpersonal aspect of treatment and the therapeutic alliance. Within this dimension, loss, inner-conflict and socio-cultural context, emerge as significant factors to situate and meaningfully interpret individuals' experiences. In the discussion, key findings are evaluated in relation to existent literature in the field, and methodological limitations considered. Particular attention is paid to how findings can be used to inform Counselling Psychology practice with female problem gamblers. Recommendations for future research are suggested. Designing, implementing and writing up this piece of research has been an enlightening process. I have learned critical research skills and been privy to real life, raw accounts of clients' experiences in treatment, an invaluable and humbling endeavour which has imprinted upon my clinical work and inspired me to continue seeking ways in which to understand and support underrepresented populations in my therapeutic practice as a Counselling Psychologist.

Section B: A Case Study

This section presents a reflective case study which forms the practitioner component of my Doctoral Portfolio. It is intended to show an example of my clinical work, incorporating my growth and development as a practitioner Psychologist, integrating new models and shifting towards a more relational approach. It illustrates my work within my chosen specialism, cognitive-analytic therapy (CAT), which views the self as social and relational, and explores the valuable effects this may have on clients with interpersonal difficulties with its empathic, client-led, relational and process-oriented focus. The client I have discussed had long term difficulties maintaining relationships, experiencing high levels of emotional distress, with repeated crises. This was in the context of a neglectful childhood. This study demonstrates how the therapeutic relationship, individual sense making and collaborative working were key facilitators of positive change for the client. Our therapeutic journey together was, at times, intense, stuck and unpredictable, however with the foundations of a strong therapeutic alliance and trust in place, we were able to weather turbulent patches, highlighting the importance of maintaining a relational stance.

Section C: Publishable Article

In this section, I provide a deeper exploration of Barriers to Treatment for female problem gamblers, a prominent theme to emerge from my overall research findings, with the aim of being published in the *Journal of Gambling Studies*. This area was considered to warrant closer attention, due to current difficulties service providers experience in engaging and treating this population, combined with the paucity of existing research into barriers and motivations for treatment. Two categories of internal and external obstacles which appear to have an impact on service utilisation are critically discussed. Once again, the relational aspect of participants' experiences stands out as being a potential barrier to seeking treatment. It is therefore argued that careful attention should be paid to the therapeutic alliance and in ensuring female problem gamblers feel understood, rather than labelled or pushed into a box, in order to better engage this population. The *Journal of Gambling Studies* was selected with its particular focus on aspects of controlled and pathological gambling behaviour and related problems including mental health issues. Its international readership of gambling experts from a cross-section of disciplines, including psychiatry, psychology, sociology, political science, criminology, and

social work, would help facilitate wide dissemination with an impact factor of 2.9. The formatting of the text is in adherence with the journal guidelines.

Development of Thesis

My interest in the experience of treatment for female problem gamblers was sparked while working in a placement at the [redacted] during the first year of my training. Working in a clinical capacity illuminated just how easy it can be to slip into problem gambling territory with devastating consequences. When working with clients, I was moved by their level of distress and the terrifying effects of their problematic gambling behaviour. Individuals I met commonly described their deteriorating overall functioning; changes in their demeanour and personality and sheer desperation to escape the vicious and unrelenting cycle of gambling, whilst feeling trapped and aggrieved by the increasing availability of gambling facilities and advertisements.

In particular, I was struck by just how few women came forward for treatment, despite evidence of increasing numbers of women gambling. During my two years working in this setting, providing short-term interventions to approximately seven clients per week, I treated only three women, one of whom disengaged due to childcare issues. This was in stark contrast to my experience of working in other clinical settings where women were more prevalent than men, including: a specialist eating disorder unit for adolescents, a Holocaust Survivors Centre, a Community Mental Health Team (CMHT) and inpatient unit for older adults, and a secondary care service for clients presenting with interpersonal difficulties. Multidisciplinary team meetings at the [redacted], further illuminated ongoing difficulties in engaging and treating female problem gamblers, despite efforts to reach them with targeted campaigns and dedicated women's groups.

The few women I was fortunate enough to work with, appeared to have different types of presentations and concerns, with complex histories and more co-morbidities than their male counterparts. I found myself needing to tailor the 'manualised' cognitive-behavioural therapy (CBT) more for these women, and wondering whether eight sessions was enough. I became fascinated by the discrepancy and increasingly curious about the factors that might be impacting on women's overall gambling and treatment experiences, wanting to understand this phenomenon. Preliminary conversations with colleagues and professionals working in other problem gambling specialist services revealed similar trends, not only on a national level, but

also internationally. I was invited to present [redacted] clinic data on women at an international conference on 'Gender Issues in Gambling' in Germany, which brought together professionals who were also looking for answers. Further investigation of existing literature and data revealed large gaps in knowledge about this topic, prompting my commitment to embarking on a research project to investigate it further.

The title, 'Switching the Lens: Using a Relational Stance to See Beyond the Disorder', has emerged from the synthesis of each piece of work incorporated in the portfolio and the overall findings which emerged. The desire for an individualised approach was implicit in the women's narratives in the research and case study. While I do not have the scope to enter the contested debate of 'disorder' here, this research has prompted a deepening consideration for taking a more person-centred approach and maintaining a strong relational stance in my practice, shifting the focus away from 'the disorder'.

While the portfolio focuses on women, this has developed through opportunity and identification of a gap in knowledge, rather than any personal or professional identification with feminist ideals. However, the learnings and insights I have gained will certainly inform my future practice.

Considered together, these pieces of work illustrate my allegiance to the scientist-practitioner role of a Counselling Psychologist. Whilst tensions are inherent in attempting to marry the demand for rigour and accuracy with the need to be creative, I feel I have reaped the benefits of experiencing and working through some of these conflicts with open curiosity. Straddling this dual role has enabled me to draw on psychological skills, knowledge and theory to make professional judgements. Highlighting the interlinking aspects of this model, my research was inspired by my clinical practice and my clinical practice has since been inspired, influenced and informed by my research. I expect this iterative process to continue.

Themes Permeating Throughout the Portfolio

Each constituent part of the portfolio is linked by the overriding theme pertaining to 'interpersonal relationships' for women, and their deep need to feel accepted and understood, both within and outside of the therapeutic encounter. The detrimental effects upon the women who have experienced a deficit in this area, for example through childhood abuse or neglect, are illuminated by each of the components which make up the portfolio. This theme of relating

to others is an integral issue within the discipline of Counselling Psychology, which seeks to understand individual difference, placing the therapeutic alliance at the very 'heart' of practice.

Counselling Psychologists increasingly work in a variety of contexts, which involve developing a therapeutic relationship with distressed individuals who are experiencing problems with their mental health. In order to make sense of these experiences, and differences it is tempting to search for classification of 'disorder'. However this portfolio highlights how 'labelling' individuals can lead to depersonalising the therapeutic experience and further avoidance on behalf of the client. This highlights one of the challenges for Counselling Psychologists infiltrating the NHS and other organisations dominated by the medical model, with tensions inherent in retaining our humanistic roots. Whilst encouraged to adapt our practice to meet the needs of different groups and individuals, the reality of service legislation, protocols, guidelines and targets can be constraining. I hope to shine a light on the importance of individualised interventions, driven by a strong therapeutic alliance, for more effective treatment, which may result in longer term cost savings.

Theory and Practice of Counselling Psychology

The development of this thesis has clarified my positioning as a Counselling Psychologist professionally and intellectually. It has also highlighted some of the more contentious issues inherent in the field and has encouraged me to think about my future practice and where I fit into the wider social context, the field of psychology and mental health. The theme of 'interpersonal relationships' extends beyond the scope of working with clients, as I have developed important relationships throughout my training with peers, colleagues, supervisors, and tutors. Some of these have been instrumental in my development and learning process, influencing my style and aspirations. I hope that building professional relationships as an independent practitioner, but also part of a team, will remain central to my practice and may lead to future collaborations.

I have adhered to the underlying humanistic principles of Counselling Psychology throughout the research process, which has helped to inform the positioning of the women included in the study. My choice of phenomenological enquiry, has been informed by my own beliefs, experiences and values, as well as my wish to provide a platform for the voices of these individuals to finally be heard. Through dissemination of findings, it is my intention that this research may contribute in some small way towards furthering evidence-based practice.

I have chosen to specialise in the theory and practice of cognitive-analytic therapy. With its social and relational focus, this inevitably influenced the methods of making sense of the data, as well as my suggestions of clinical implications throughout the thesis. Over the course of my training I have practiced in a variety of other therapeutic models, including CBT and psychodynamic therapy, which also inform my practice and are useful to draw from. The potential to work with these different therapeutic approaches emphasises the centrality of relationship and the intersubjective nature of the therapeutic process. It also requires careful reflection and review of application of practice.

The process of compiling this thesis has been exciting, eye-opening, stimulating, rewarding, challenging and vast, which also reflects my experience of my professional training. The process has helped me to refine my professional commitments, values and goals through in-depth reflection on my role as both a scientist and practitioner.

SECTION A – DOCTORAL RESEARCH

The Experience of Treatment for Female Problem Gamblers

Anna Kaufman

Supervised by Dr Jessica Jones Nielsen

Abstract

The recent relaxation in gambling laws, combined with an increase in availability of gaming facilities online and on high streets, plus increased advertising has been linked to a rise in problem gambling in the United Kingdom. Researchers assert that gambling support services often do not meet the needs of people seeking help for their gambling problems. In particular, the gender-specific needs of males and females are neglected. Previous studies have found significant differences between males and females with gambling problems, indicating differing treatment needs, yet the majority of research is quantitative and mainly focuses on male samples. In response to the deficit of qualitative research in this area, this study has investigated the lived experience of female problem gamblers who have presented for treatment at the [redacted] in London. Participants were eight women who received individual cognitive-behavioural therapy treatment at the clinic. Three main themes emerged from the interview data: 1) running from the pain of loss; 2) the conflict of seeking treatment; and 3) negotiating relationships. The findings provide insights into women's perspectives on the experience of seeking and receiving treatment, including the internal and external barriers that they face and some of the challenges they must overcome throughout their treatment journey. A compelling relational dimension emerged from their accounts, and their experiences were found to be fundamentally founded on their experiences of relationships. This supports the notion that more attention should be paid to the interpersonal aspect of treatment and the therapeutic alliance. The implications of the emergent themes are discussed with particular reference to informing Counselling Psychologists and service providers about how to improve treatment intervention as well as informing policy makers.

Key words: Female; treatment; problem gambling; cognitive-behavioural therapy; barriers

"There was no help for female gamblers so in the end I went to the social service substance misuse team and I told them I had a drug problem"

CHAPTER 1 - INTRODUCTION

In order to situate the present study within a meaningful context, I will introduce and define the topic of problem gambling and describe the current landscape for gambling in the United Kingdom (UK), placing it in a socio-cultural context and commenting on types of gambling that are currently prevalent. I will provide statistical data, locating women within this picture before I move on to discuss some of the main theories of problem gambling, drawing from different perspectives including addictions theory, social learning theory and psychodynamic theory, considering the implications of these for treatment. I will then describe treatment options available in the UK for problem gambling. Next I will review the small body of existing literature available on women problem gambling and treatment. I will then explain my rationale for conducting this study, considering the significance of the topic for the field of Counselling Psychology and beyond.

1.1 Defining and Understanding Problem Gambling

Gambling is defined in Collins English Dictionary (2003) as 'to bet, wager or other risk of chance taken for possible monetary gain'. Different terms have been put forward to classify individuals according to how much they gamble, although a universal diagnostic label has not been agreed upon to describe individuals who gamble compulsively. Common terms include 'problem', 'compulsive', 'at risk', 'pathological' and 'disordered' gambling. Castellani's (2000) book, which explores the history and medicalisation of 'pathological gambling', covers this debate in more detail. Blaszczynski and Nower (2002) warn that this lack of consensus regarding categorisation poses the risk of merging problem gamblers and gamblers with problems in this area into 'one homogeneous group'. This has negative implications for treatment, since it should not be assumed that one size fits all. They emphasise the defining feature of a problem gambler is not only the emergence of negative financial, psychological and social consequences but also the presence of a subjective sense of impaired control and inability to regulate impulses to gamble (Blaszczynski & Nower, 2002). LaPlante, Nelson, LaBrie, and Shaffer (2006) propose that 'disordered gambling' is characterised in particular by greater gambling involvement rather than any specific type of gambling. The Responsible Gambling Strategy Board (RGSB) in the UK states that gambling related harm is:

> *"the adverse financial, personal and social consequences to players, their families and wider social networks, that can be caused by uncontrolled gambling" (RGSB, 2012, p. 10).*

Along with disputes regarding the terminology and classification of individuals who gamble problematically, there has been heated debate around the aetiology and classification of problem gambling itself. Diagnostic and social ambivalence dates back to 1980 when the American Psychiatric Association (APA) first accepted and introduced problematic gambling as a psychiatric disorder (Shaffer & Martin, 2011). With the recent publication of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), 'pathological gambling' was re-classified from an Impulse Control Disorder to Behavioural Addiction and re-termed 'gambling disorder'. Shaffer and Martin (2011) warn that conceptualising addictions in this way risks misperceptions that the object (i.e. gambling) causes the addiction. They propose that an addiction diagnosis should remain independent of its object, focusing instead on identifying the core features of addiction. In the DSM-5, The APA defines a 'gambling disorder' as:

> *"persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress" (section 312.31).*

This is categorised using nine conditions, at least four of which must be met in order to fulfil the diagnosis. These conditions range from 'repeated unsuccessful efforts to control, cut back, or stop gambling', to 'loss of a significant relationship, job, or educational or career opportunity because of gambling' through to 'reliance on others to relieve desperate financial situations caused by gambling' (see Appendix A). The current diagnostic system and uncertainty about DSM categories have been criticised on the basis that they are determined by a committee, rather than by science, leaving them susceptible to error (Schmidt, Kotov, & Joiner, 2004). Furthermore there is a significant debate about the relative validity of a categorical versus a dimensional system of classification. Another diagnostic tool used to measure problem gambling is the Problem Gambling Severity Index (PGSI) (see Appendix B) which was developed for use in population-based studies. For clarification in this study the term 'problem gambling' will be used to refer to individuals or participants who fitted the PGSI criteria at the time of their assessment for treatment, and they were also screened using the DSM-5 criteria for severity of a gambling disorder.

Problem gambling is an important concern since it is associated with significant social, economic and health costs on both an individual and societal level. Broad societal

consequences include financial loss, the destruction of family and community relationships, loss of home or job and involvement in illegal activities (National Gambling Impact Study Commission, 1999). Health related problems can include depression, anxiety, insomnia, gastric disorders, migraines and other stress related disorders (Griffiths, 2004). Increased suicidal ideation and attempts have also been identified among problem gamblers (Phillips & Smith, 1997; Potenza, Steinberg, McLaughlin, Rounsaville & O'Malley, 2001). The total lifetime costs that problem gamblers in the UK incur and the annual social costs associated with problem gambling are difficult to gauge and prone to measurement errors. Factors that need to be taken into account include accessing social support services and benefits, disrupted productivity, and creditor losses.

1.2 Prevalence of Problem Gambling in the UK

In recent years the gambling landscape in the UK has changed dramatically. The introduction of The Gambling Act 2005, which came into effect in 2007, has allowed the responsible advertising of gambling and the introduction of licensed online gambling, making it possible for problem gamblers to access gaming facilities twenty-four hours a day. In the UK, gambling is positioned as a legitimate recreational and leisure activity, under the responsibility of the Department for Culture, Media and Sport. However there is increasingly widespread recognition among policy makers, industry and healthcare professionals that gambling can cause harm. In 2012, for the first time, questions on gambling activity were included in the Health Survey for England (HSE). Data showed 68% of men and 61% of women participated in gambling activities between 2011 and 2012. Among both men and women, prevalence of online gambling (excluding the National Lottery) was higher among younger age groups and lower among older age groups. Among women, 6% to 7% of the 16-34 age group participated in online gambling, decreasing to 3% or less among those aged 45 and over. Findings indicated that 0.8% of men and 0.2% of women were identified as problem gamblers (Wardle & Seabury, 2013). Since this was the first study of its kind it has not been possible to find patterns over time.

According to the latest British Gambling Prevalence Survey, commissioned by the Gambling Commission, which regulates gambling activities in the UK, there are between 360,000 and 450,000 adult problem gamblers in the UK. The prevalence of male problem gambling increased from 1% in 2007 to 1.5% in 2010, while female problem gambling increased from 0.2% in 2007 to 0.3% in 2010, which translates to 75,000 women in Great Britain (Wardle et

al, 2011a). Notably the increase in overall scores for women was driven by younger women. The survey also found a general increase in participation in gambling since the 2007 survey from 68% to 73%, and this increase was greater among women than men (65% in 2007 and 71% in 2010). Since gambling participation seems to be increasing faster among women than men, there may be differences in reasons for gambling requiring different treatment needs which warrant further examination.

1.3 Types of Gambling and the Internet

Perkins (1950) proposed that gambling could be segmented into four factors include gaming, betting, lotteries and speculation. Historically in Britain, gambling has been focused around sports, casinos and betting shops. With the rise of information technology and new media, the gambling field has changed significantly over the past five years, which has resulted in a shift in gambling attitudes and motivation (Parke & Griffiths, 2012). The BGPS provides evidence of changes in gambling behaviour in Britain including gambling participation, activity preferences and attitudes towards gambling, for both men and women (Wardle et al, 2011a). In particular, several types of gambling were less male orientated in terms of participation. Notably, the National Lottery (56% of women, 61% of men), other lotteries (both 25%), slot machines (16% of men, 10% of women), and online betting excluding lotteries, bingo, football pools, casino games and online slot machines (15% of men, 11% of women). Others participated in slightly (scratch cards 23% of men, 25% of women) or substantially (bingo 6% of men, 12% of women) more among women. There are indications that online gaming participation has increased more for women than men since 2007 (3% and 5% respectively). The availability of new software, particularly through the internet, has facilitated gambling via social networking, internet gambling, interactive television gambling and mobile phone gambling. This is combined with the introduction of national lotteries, the proliferation of gaming machines and the expansion of casinos, all of which have greatly increased the accessibility and popularity of gambling, and, as a result, the number of people seeking assistance for gambling-related problems (Abbott, Volberg, Bellringer, & Reith, 2004).

1.4 Gambling and Social Context

While gambling has traditionally been perceived as a male recreational activity (Potenza, Steinberg, McLaughlin, & Rounsaville, 2001) and a male addiction, recent gambling prevalence studies indicate that the gap is narrowing as greater numbers of women are

gambling. The gambling industry is located within a cultural and social context in which it strategically designs and markets its games and products to particular population groups. For example, online bingo appeals to women who wish to socialise with online communities where members can send each other messages (Wardle, 2015). Illuminating the recent proliferation of gambling promotions and advertising, an Ofcom report (2013) found that the number of gambling commercials on British television increased from 234,000 a year to nearly 1.4m annually since the deregulation of the sector. In particular, bingo, online casinos and poker commercials (all of which appeal to women) represented a greater number of gambling advertising slots between 2006 and 2012. According to the report, in 2012, 532,000 bingo television adverts were aired, 411,000 commercials for online casino and poker services, 355,000 for lotteries and scratch cards, and 91,000 sports betting. Political and societal concern regarding the aggressive nature of these adverts, which may impact on vulnerable consumers, prompted a review of gambling advertising in the UK by the Advertising Standards Authority (ASA, 2014). The review concluded that the general public are 'largely satisfied with the way gambling advertisements are regulated' although this report has been described as 'fundamentally flawed' and 'lacking context' (Archer, 2014, p1). Lending further support to the significance of context in understanding gambling behaviour, Hing and Breen (2001) argue that 'social norms' may have contributed to different patterns of male and female preferences, since gambling has become more accessible and arguably culturally acceptable for women in the UK. Griffiths (2003) also claims that gambling acquisition is the result of sociological rather than psychological or biological factors. He proposed that parental encouragement and acceptance of fruit machine playing contributed to the gambling behaviour in the case of one adolescent female who had been addicted to playing on fruit machines. It is therefore argued that gambling behaviour should be considered within this socio-cultural context.

The notion of a 'feminisation' of gambling and problem gambling has been proposed in the US, Canada and Australia, which refers to the idea that more women are gambling, developing problems and seeking help for problems related to gambling than in the past. (The Productivity Commission, 1999). This notion has been linked to the availability of gaming machines in these countries (Holdsworth, Hing, & Breen, 2012; Volberg, 2003), however statements such as this should be approached with caution since there are multiple variables to consider when trying to draw causal links. For example, ethnicity, age and social class may also play a role in what type of gambling people choose and who gets into difficulties with gambling (Volberg, 2003).

Wardle (2015) argues that there has been a 're-feminisation' of gambling in the UK. She proposes that changes in gambling behaviour among women are the result of changing regulatory frameworks as the gambling industry seeks to recapture a key population group, pointing to womens' preferences for gambling in the 1950s. She discusses how gendered constraints affect behaviour, arguing that 'changes to the way women can access gambling influence normative environments as gambling is now promoted freely as a valid leisure and recreational choice' (Wardle, 2015, p. 293). Some of these patterns are evident from data provided in government health surveys including the BGPS and Health Survey for England which highlight increasing numbers of females gambling in addition to types of gambling which are popular among women. These findings are important because they illustrate how behaviour varies among different types of women in different contexts and situations. Sociological theories such as gender role theory and socialization, subcultural differences in the gambling industry, capital theory and cultural geography, may shed some light on concerns particular to women over the life course (Holdsworth et al., 2012). However these ideas are also important from a psychological perspective since they highlight the urgent need for healthcare professionals to be aware of this specific, emerging group.

Korn and Shaffer (1999) were among the first to advocate that a public health framework should be applied to gambling in the 1990s, which would take into account social context. They emphasised focus on the individual, the form of gambling undertaken, the environment in which behaviour is conducted, and the interactions between these three aspects (Korn & Shaffer, 1999). Currently in the UK, problem gambling is monitored, but this approach is criticised since it fails to recognise those 'at risk' of developing a gambling problem. A public health approach is therefore called for to investigate problem gambling at a deeper level in the UK (Wardle et al., 2011b). The Responsible Gambling Trust (RGT), which raises funds to support gambling treatment and harm prevention activities, has also backed this notion, commenting on its website homepage (under the subheading Gambling-related harm: a public health issue)

> *'Public Health England, NHS Foundation Trusts and all local health commissioning agencies ought also to provide treatment and harm prevention services for problem gambling alongside services for those struggling with alcohol- and drug-related problems.' (RGT)*

1.5. Theoretical Basis for Problem Gambling

Several models of problem gambling have been put forward to explain different aspects of the sociological, biological and psychological processes which are involved in the aetiology of problem gambling and therefore they may help explain progression from 'recreational gambling' into problem gambling. These models are not mutually exclusive and share common elements. Due to the limited scope of this study, I briefly outline the following three models which hold significant relevance: The addictions model, the social learning theory (which includes the cognitive-behavioural model) and the psychodynamic model.

1.5.1 Addiction Theories

Jacobs' Addiction Model views addiction as 'a dependent state acquired over time to relieve stress' (Jacobs, 1986, p. 15). According to Jacobs, two interrelated sets of factors predispose individuals to addictions: an abnormal resting state, and childhood experiences which produce a deep sense of inadequacy. Firstly, the presence of an abnormal physiological resting state is thought to leave the individual under- or over-aroused. Individuals with an under-aroused resting state may be susceptible to a gambling problem, since they may seek relief from boredom through external stimulation such as gambling. Secondly, psychological characteristics such as low self-esteem and feelings of inferiority are deemed pre-disposing factors for a gambling problem. Jacobs suggests that both these factors, along with a conducive environment, must be present for an individual to develop and maintain an addiction. He therefore asserts that gambling addiction is more likely to occur in depressed, bored, under-aroused individuals with low self-esteem. In recent years there has been growing consensus (Sussman, Nadra & Griffiths, 2011) that a number of behaviours, including gambling, are potentially addictive, including those that do not involve ingesting drugs or consuming alcohol. Caution, however should be taken by taken by clinicians to avoid pathologising every day behaviours. Models of addiction (or the disease model) have been widely criticised as stigmatising (Burglass & Shaffer, 1984; Griffiths & Larkin, 2004; Peele, 1980), with an emphasis on internal disease which may absolve the problem gambler from taking responsibility for the problem. In addition they fail to take into account individuals who develop a gambling problem with no reported depression or co-morbidity prior to gambling.

1.5.2 Social Learning Theory – Cognitive-Behavioural Theories

Behavioural frameworks, underpinned by Social Learning Theory (Bandura, 1971), propose that gambling is a learned behaviour and that event stimuli in a gambling environment such as

flashing lights, spinning wheels or hypnotic music, acts as reinforcement. This reinforcement is thought to contribute to the individual's experience of excitement and the biological experience of raised autonomic arousal. In this way the individual seeks pleasurable experience through learned responses and rewards. Neuroimaging studies have provided evidence that gambling activates the brain's reward system, or limbic system by increasing the release of the neurotransmitter dopamine in the mesolimbic pathway, creating feelings of pleasure (Van Holst, Brink, Veltman, & Goudrian, 2010). A prominent symptom of problem gambling is experiencing urges in response to stimuli, which often lead to relapse. Sharpe and Tarrier (1993) propose that both operant and classical conditioning can be useful in explaining gambling behaviour, asserting that gambling is maintained by the winning and losing sequences with a variable interval schedule of reinforcement. While gambling behaviour is reinforced through financial rewards it is proposed that gamblers may persist despite losses, since they learn that wins may be intermittent and therefore persistence is necessary for wins to occur. Cognitions are also thought to play an important role in the development and maintenance of a gambling problem. Cognitive theorists propose that gambling persistence is fostered by unrealistic or irrational thinking (Sharpe & Tarrier, 1993). It is thought that gamblers who misinterpret the causes of wins and losses, and develop a belief system that they will be successful at gambling, become more susceptible to problem gambling. Two common cognitive biases that have been widely studied include The Gamblers Fallacy (Clotfelter & Cook, 1993) which refers to the idea that an outcome is more likely to occur because it hasn't for some time, and The Illusion of Control (Langer, 1975) which refers to the belief that it is possible to control an outcome that is uncontrollable. Cognitive-behavioural theories have been criticised for ignoring early traumatic life experiences and for failing to take into account more subjective experiences and meaning of observable behaviour. (Beidel & Turner, 1986)

1.5.3 Psychodynamic Theories

Psychodynamic theories propose that individuals engage in problematic behaviours such as excessive gambling in an attempt to resolve unconscious psychic conflicts which are beyond voluntary control. Driven by these conflicts, thought to be linked to early childhood traumas and deprivations, the individual continues to participate in the gambling activity in an unsuccessful attempt to ease psychological pain, unaware of their own true motivations.

Within the psychodynamic theories, attachment theory has provided an approach to understanding and treating addiction (Flores, 2006; 2011). Attachment theorists assert that

early attachment experiences with caretakers, combined with their biological and affective consequences, develop into an internal working model of self and others. Bowlby (1973) (cited in Holmes, 1993) proposes that this internal model is based upon a judgment about the dependability and responsiveness of the attachment figure, and a judgment about self-worth. Over time, the infant learns what to expect in the relationship. Attachment theorists propose that if an individual has an insecure attachment style, or did not receive enough nurturing during early stages of life, they will find it challenging to maintain their self-esteem and attempt to regulate affect or emotion through gambling, which ultimately fails and reinforces the relational problems from which the negative affective state originates.

Freud (1954), who attributed gambling problems to unfulfilled oedipal desires, compared the excitement of gambling to sexual arousal, proposing gambling is a substitute for masturbation (cited in Aasved, 2002). In a letter to a colleague (1897) he asserted gamblers play to relieve intense feelings of guilt through masochistic self-punishment; implying they play to lose rather than win and through these losses, find a means to redeem themselves and offset guilt. Unlike his predecessors, Bergler (1958) distinguished normal from abnormal gambling. He was also among the first to acknowledge that women could also be 'neurotic' gamblers. He classified various types of gamblers, categorising all female gamblers as 'classical types' (cited in Aasved, 2002). Boyd and Bolen (1970) identified loss as a prevalent theme for gamblers, proposing that gambling may represent a 'manic defensive manoeuvre' to temporarily distract individuals from the loss of loved ones and other traumas along with their own depression. In this way, they deny death itself (cited in Aasvad, 2002). Rosenthal (1987) claimed that the majority of compulsive gamblers are narcissistic with feelings of inadequacy that lead to the creation of a fantasy world in which gambling is seen as a solution, creating an illusion of power. Rosenthal identified defense mechanisms employed by problem gamblers: omnipotence, splitting, idealisation and devaluation, projection and denial, placing these into the context of the therapeutic encounter. One of the limitations of psychoanalytic theory is that it lacks empirical evidence and predictive power. Historically it has also failed to acknowledge female problem gamblers (Aasved, 2002).

1.5.4 A Multidimensional Approach

As demonstrated in this brief summary of models, while each individual theory provides useful insights into the motivations and possible causes of problem gambling, they highlight the complexity and multifactorial nature of the phenomenon of gambling. Griffiths (2005) proposes

a more ‘eclectic’ approach which combines ideas from different perspectives in order to overcome limitations of individual perspectives. Contemporary research attempts to take into account social and biological components, viewing problem gambling as multidimensional. For instance, Blaszczynski and Nower’s ‘Pathways Model’ (2002) identifies three main subgroups of problem gamblers. It recognises the role and implications of underlying vulnerability features, demographic features and aetiological processes present in problem gamblers. They propose that: a) the ‘behaviourally conditioned’ subset of problem gamblers lack specific pre-morbid features of psychopathology. It is argued that high levels of depression may be present in this population as a consequence of problem gambling; b) the ‘emotionally vulnerable’ subset of problem gamblers has the same cognitive schemas as the ‘behaviourally conditioned’ subset; however, this group more commonly present with pre-morbid issues of depression with evidence of poor coping history and /or negative childhood experiences; individuals within this subset may gamble to regulate their emotion; c) the ‘anti-social, impulsivist’ subset of problem gamblers is likely to have biological and psychosocial vulnerabilities present; these may be highly disturbed individuals, displaying multiple maladaptive behaviours and impulsivity suggesting they engage in a wider array of problematic behaviours independent of their gambling, such as suicidality, criminality, and substance abuse. Therefore, there is some consensus that single domain models are inadequate and limiting in scope (Griffiths, 2005; Blaszczynski and Nower, 2002).

1.6 The Treatment of Problem Gambling in the UK

As evidenced by studies (Wardle et al., 2011a; Wardle et al., 2013), more people are gambling and there is evidence that problematic gambling is increasing, therefore demand for treatment is expected to rise. Yet research shows that relatively few people with gambling difficulties seek treatment (Blanco, Hasin, Petry, Stinson, & Grant, 2006; Cunningham, 2005) as problem gamblers appear unwilling to admit their problems and tend to present for treatment when the severity of their difficulty drives them to treatment as a last resort (Suurvali, Cordingley, Hodgins, & Cunningham, 2009), or they have reached a crisis point (Bellringer, 2008). There are also indications that a large percentage of those who seek help discontinue treatment prematurely (Grant, Kim, & Kuskowski, 2004). This can result in serious negative consequences for the gambler or their family, including suicidal thoughts or relationship breakdown (Carroll, 2011), posing additional challenges for treatment providers. At present the National Institute for Clinical Health and Excellence (NICE) does not offer any guidelines for the treatment of individuals with a gambling disorder. In addition to this lack of ‘best practice

guidelines' there are varying approaches for treatment. This murky path for treatment is arguably further fuelled by existing disagreements about what counts as a gambling 'problem', as previously discussed. The intervention options for the treatment of problem gambling include counselling, psychotherapy, CBT, advisory services, residential care, pharmacotherapy, and combinations of these (Griffiths,1996; Griffiths & MacDonald, 1999). In 2007 the British Medical Association (BMA) proposed that the NHS should provide sufficient support for gambling disorders, alongside the services it provides for drug and alcohol problems. However a recent study which examined the outcome of this recommendation found that 97% of the Trusts did not provide any service to treat people with gambling problems, and services were not geographically available or accessible for problem gamblers (Rigbye & Griffiths, 2011). Current provision for problem gamblers is provided mainly by the third sector and historically has not provided equal support for women. It is argued that this is a failure of the public health system in not viewing problem gambling as a public health issue (Rigbye & Griffiths, 2011) and in this way, the treatment needs of problem gamblers are not being met. This illuminates some of the challenges for Counselling Psychologists and service providers in the UK to consider, highlighting the need for more research in this area and co-ordination between professionals working with problem gamblers. Below is a table listing dedicated gambling treatment centres and services in the UK, sector information, services offered and a breakdown of numbers of patients seen per year, where available. There is not currently a private treatment centre dedicated to gambling in the UK.

Table 1.1 UK Treatment Centres for Problem Gambling

Treatment Centre	**Opened**	**Sector**	**Services offered**	**N patients treated per year (2013)**
[redacted]	2008	NHS	8 sessions individual or, group CBT, 12-15 sessions Psychodynamic therapy	736
Gamcare	1997	Charity	Helpline, face to face or online counselling, 12 sessions Psychodynamic therapy	800
Gordon Moody Association	1973	Charity .	Therapeutic support through residential, online and outreach services	70 (18 bed spaces across 2 centres)

Gamblers Anonymous	1964	Charity, supported by Responsible Gambling Trust	12 step meetings	Unknown
Gam-anon UK	Unknown	Charity	Fellowship of relatives or close others to those with gambling problem	Unknown

1.6.1 [redacted] and Female Attrition Rates

One gambling treatment service in particular is the [redacted] which opened in 2008 and is funded partly by the Responsible Gambling Trust. It is currently the only NHS multidisciplinary treatment centre in the UK for the treatment of problem gambling with only one branch located in London.

[redacted] offers group or individual CBT interventions. In 2012 – 2013, the clinic received 736 referrals for all treatment episodes with just 47 being female, which equates to 7- 8% of total referrals, a figure which has remained static since 2009 [redacted] 2013) and is significantly lower than the estimated growing 17% of female problem gamblers in the gambling population (Wardle et al., 2011). It was also found that women were less likely to attend an offered assessment than men (69.4% compared with 80.6%). In addition, women who attended the assessment and were referred for treatment were less likely to have a 'planned' discharge than men (40% compared to 63.8%, [redacted] 2013). The clinic has trialled specific services for women such as an all-female group; however up-take remains low. This is in contrast to the trend seen elsewhere in mental health, where women are more likely to seek treatment than men. In 2007 the NHS published statistics reporting that 29% of adult women were being treated for mental health disorders compared to 17% of men seeking treatment, despite similar levels (Halliwell, Main, & Richardson, 2007). These findings suggest that a deeper examination of women's experience of treatment for problem gambling is warranted to explore the diversity and experiences of women. This has provided the inspiration for this study. It has been difficult to obtain attrition rates for females compared to males in treatment centres internationally, highlighting another gap for research. Although similar patterns have been identified in Germany, where inpatient treatment is a dominant model for treating problem gambling. Women account for only 10% of clients in outpatient and inpatient clinics in Germany, yet one third of affected gamblers are thought to be women (Buchner et al., 2015).

1.7 Literature Review

In this next section I will review a selection of published papers considered most relevant to the current study. It seems important to bring to the reader's attention the paucity of research from the UK, with much research emanating from various parts of the world, in particular Canada, the US and Australia. While international research throws light onto the plight of female problem gambling, direct comparisons may not be possible since the gambling landscape in Britain differs from that of other countries. In addition, many of the papers reviewed focused on the following key words: 'the experience of' 'female', 'problem gamblers', 'in treatment'. However, only a few papers included every k ey word since there is limited existing research on this topic. Notably most of the reviewed research is quantitative.

1.7.1 Gender Differences in Problem Gambling

Female problem gamblers have been found to have many different attributes to those of male problem gamblers (Brown & Coventry, 1997; Crisp et al., 2004; Echeburua, Gonzalez-Orgega, de Corral, & Polo-L´opez, 2011; Grant, Chamberlain, Schreiber & Odlaug, 2012; Ladd & Petry, 2002; Martins, Storr, Ialongo & Chilcoat, 2008; Wong, Zane, Saw, Chan, & Ki Chan, 2012). Research has identified differing clinical characteristics, demographic characteristics, preference for different types of gaming activities, as well as differing emotional states and motivational factors related to gambling among women, all of which have important implications for those seeking help, highlighting the need for a specialised intervention.

Female problem gamblers are likely to be older than their male counterparts (Echeburua et al., 2011; Grant & Kim, 2002; Ladd & Petry, 2002), start gambling later in life (Ladd & Petry, 2002) with a more rapid progression into problem gambling or 'telescoping' (Blanco, et al., 2006; Grant & Kim, 2002). Female problem gamblers are more likely to be married, to have dependants (Crisp et al., 2004) and to have smaller debts owed than those of males. Life experiences are predictors for female problem gamblers including level of education, childhood exposure to gambling, number of marriages, frequent changes of residence, and alcohol consumption (Hraba & Lee, 1996). These themes are repeated frequently in literature on womens patterns of gambling behaviour, indicating that they have some basis in fact. While the sparse body of previous gender-specific gambling research has highlighted differences between male and female problem gamblers, it fails to consider what these differences mean for women in treatment.

1.7.2 Gambling as an Escape-Based Strategy

Reports from treatment providers frequently indicate that women gamble to escape their social and emotional reality and difficult feelings such as boredom, loneliness, anxiety and depression (Blanco et al., 2006; Brown & Coventry, 1997; Karter, 2013; Potenza et al., 2001; Volberg, 2003) compared to the hope for possible gains and sensory stimulation seen in male problem gamblers (Ibáñez, Blanco, Moreryra, & S´aiz-Ruiz, 2003). This correlates with findings that female problem gamblers are more likely to present with co-morbidities than males, are more anxious, have lower self-esteem and are more affected by depressive symptoms (Echeburua et al., 2011). The same study found that 68% of female participants were victims of intimate partner violence (Echeburua et al., 2011). Linking back to Blaszczynski and Nower's 'Pathways Model' (2002) this suggests women often fit into the 'emotionally vulnerable' subset of problem gamblers who commonly present with pre-morbid issues of depression, with evidence of poor coping history and tendency to gamble to regulate their emotions (Thomas, Allen, & Phillips, 2009a). This desire to escape is reflected in the types of activities that female problem gamblers participate in, as well as their gambling patterns, which differ from those of male problem gamblers (Hing & Breen, 2001; Hraba & Lee, 1996). It is frequently reported that women prefer to play games of chance rather than skill (Potenza et al., 2001; Volberg, 2003; Svensson, Romild, Nordenmark & Månsdotter, 2011; Holdsworth et al., 2012) while males tend to be multi-game players, prefer games of skill such as sports games, racing, cards and play alone (Blanco et al., 2006; LaPlante et al., 2006). Prevalence studies support these findings, showing females are more likely to play games such as lottery, scratch-cards or bingo (Wardle et al., 2011a). A large body of research from Australia has investigated the popularity of non-casino Electronic Gaming Machines (EGMs), such as slot machines, among women, which are thought to provide relaxation or escape from problems as a form of avoidant or emotion-based coping (Thomas, Sullivan, & Allen, 2009b). This has been of particular concern since gamblers playing gaming machines are thought to be at 'greater risk' of developing a gambling problem than those who gamble on other forms (Dowling, Smith, & Thomas, 2005; Productivity Commission, 2010). EGMs are the fastest-growing sector of the gaming industry worldwide and as they proliferate, women are increasingly presenting with problems in greater numbers (Productivity Commission, 2010).

Wood and Griffiths (2007a) conducted a qualitative, grounded theory investigation of problem gambling as an escape-based strategy looking at the extent to which male and female problem

gamblers in treatment, in recovery and also those who had not had treatment, used gambling as a means of coping. Fifty problem gamblers between eighteen and sixty-three years from all over the UK were interviewed, with a focus on how their gambling had developed and the role it played in their lives. The motivations that drove the need to escape, identified through selective coding, were found to be 'mood modification needs', 'filling the void' and 'avoiding problems'. The gamblers became reliant on psychological escape achieved through gambling and used as a means by which the gamblers coped with their problem, supporting previous findings that gambling is used as a means to manage their emotions (Ricketts & Macastill, 2003); however this older study, which also used a grounded theory approach, looked at a male-only sample of fourteen treatment seeking gamblers in a range of clinical settings and findings are therefore not generalisable to women. While Wood and Griffiths (2007a) expanded their sample to include women, only seven participated in the sample of fifty. Twenty interviews were conducted by telephone and five by email, which are less ideal conditions for qualitative interviewing. Furthermore those who responded to the study recognised they had a problem and were motivated to take part, leaving a knowledge gap about participants who had not yet realised they had a problem. In addition, the methodology is susceptible to recall biases or poor memory. However findings of both studies imply that focus on managing difficult emotions in treatment would be beneficial for those who gamble to escape.

Studies investigating links between trauma and gambling behaviour (Donnely, 2009; Kausch et al., (2006) cited in Nixon et al., 2012) may shed some light on the experience of emptiness or difficult emotions, which some women seek to escape through gambling. Individuals who mistrust others may avoid seeking help and instead turn to an activity or object as a temporary relief or escape from distress. Kausch et al. (2006, cited in Nixon et al., 2012) identified a relationship between gambling and trauma although the role trauma played in the development of a gambling problem was not explored. Nixon et al. (2012) took this concept further seeking to investigate the role trauma plays in initiation, development and progression of problem gambling among women, proposing that individuals who had experienced childhood trauma may be susceptible to developing a gambling problem. They asserted that participants' 'not good enough self' created a false sense of emptiness or deficiency; the seductive, intoxicating qualities of gambling could offer an 'escape from the trauma burdened psyche' (p.17). These findings are important from a treatment perspective since they provide an approach to understanding and addressing problem gambling and unresolved trauma issues in female clients. However, while useful insights into the motivations and risk factors in problem gambling

for women are provided, they fail to consider the finer nuances that could be discovered with a more detailed investigation of treatment experience.

1.7.3 Treatment Seeking Female Problem Gamblers

A handful of studies from Canada, the US, Australia, Spain and Switzerland consider gender-specific treatment for problem gamblers; however research is still in its infancy and no research from the UK investigates treatment experiences for female problem gamblers, highlighting the gap for this study.

A recent study considers the perceived effectiveness of all-female group counselling for problem gambling in Canada (Piquette & Norman, 2012). An offshoot of this larger study looked at the effectiveness of 'therapeutic writing' or journaling as a tool (Dwyer, Piquette, Buckle & McCaslin, 2012). Twelve female participants between twenty-six and seventy-six years were selected from the counselling group and asked to write about their experiences in a journal after weekly meetings. A six month follow-up interview was also conducted for further reflection. Main themes to emerge from the larger study were a) relationships, b) learning, and c) facilitation. Journaling was found to be an effective counselling tool due to its reflective, intellectual nature. This study had several limitations, including; only four participants took part in the one-to-one interviews; it failed to take into account other ethnic perspectives and questions focused on intent to explore potential benefits of the group, thus limiting the womens' open dialogue. The journaling part of the study allowed women to write openly and honestly; however, it could be argued that journaling is not a good fit for all clients at all stages of their recovery, which may be a difficult balance to find in a group-counselling setting. Further research could consider whether treatment can be tailored to meet the unique needs of women, taking into account their roles and life experiences.

However, Dowling, Smith and Thomas, (2006a) evaluated the efficacy of a cognitive-behavioural intervention for women problem gamblers in Australia. They recruited nineteen women of between twenty-eight years and seventy years with electronic gaming machine problems who were treated with CBT. Participants, who all had the same goal of abstinence, showed significant improvement in gambling behaviour (i.e. gambling frequency, duration, money inserted and expenditure) and psychological functioning over the treatment period and maintained this at the six-month follow-up evaluation. Eighty-nine percent of participants no longer met the diagnostic criteria for pathological gambling by completion of the follow up

period, which the authors propose indicates that the therapy is effective for women problem gamblers. There are several limitations to this study, since it only considers women with gaming machine problems. It is quantitative, based around measures and diagnosis using DSM-IV criteria which recognise only the presence or absence of a clinical disorder, although as discussed previously, there is much debate around classification of a gambling disorder. Measuring gambling behaviour and psychological functioning is far more complex than ticking boxes. A small sample of nineteen women was used, making it susceptible to Type II statistical errors; participants were evaluated at completion of the treatment programme and after six months, but this fails to consider treatment longevity or sustainability. This also highlights a further problem in attempting to ascertain treatment efficacy, since rigorous scientific demonstration and replication are required to establish effectiveness of CBT and it depends on how one defines 'efficacy'.

In another study, Dowling et al. (2006b) also compared the efficacy of individual and group CBT for women. Fifty-six women problem gamblers with EGM problems were randomly assigned to either the control group or one of the treatment groups (individual or group CBT). Findings indicate superiority of individual treatment, supporting other treatment outcome studies, however there is very limited existing research to support findings. This study is susceptible to the same limitations as the previous one. To date there is a lack of research evaluating the effectiveness of other models including humanistic and psychodynamic therapies; therefore current evaluations on effectiveness of treatment do not represent the full spectrum of recovery models (Oakely-Brown et al., 2000, cited in O'Brien, 2011).

1.7.4 Treatment Attrition and Readiness to Change

Due to the lack of relevant evaluative research, the efficacies of various forms of treatment intervention are difficult to address. Some studies have compared gender in the recovery process, taking into account treatment readiness factors. A recent study examined gender differences in gambling consequences and readiness to change among callers to the State of Michigan Problem Gambling Helpline (Ledgerwood, Wiedemann, Moore, & Arfken, 2012). In total 501 participants were asked to participate and 202 agreed, of whom 118 were female and eighty-four were men. They were all over the age of eighteen and had been referred for treatment by the State helpline. Women reported greater readiness for changing gambling behaviours, mediated in part by problem gambling symptom severity, which seems relevant when considering treatment programmes, but also in associated consequences. However

interviews were conducted on the telephone with a limited duration of fifteen minutes, and data does not examine why gender differences may exist or explore the meanings for participants.

Patients with addictions, including gambling disorders, have high attrition rates ranging from approximately thirty to fifty percent (Ladouceur, 2009). To date, only limited attention has been paid to factors contributing to attrition and retention in gambling treatment. Linnet & Pederson (2014) investigated the role of waiting and comorbidity as possible predictors of attrition using a cohort of forty-eight gambling disorder sufferers with a fifty-six percent completion rate (twenty-one non-completers and twenty-seven completers). They concluded that individuals with gambling disorders benefit from fast access to treatment, and that longer waiting time increases the risk of attrition, however gender was not found to increase attrition rates. However, a limitation in the data is that it did not include patients who had not been in contact with a therapist. Another limitation was that it was not possible to evaluate treatment efficacy, since most patients in the non-completion group did not complete post treatment measures. Conclusions were drawn that those with a shorter wait were more likely to complete treatment, however there may have been other factors not taken into account, such as accessibility, ambivalence and stigma, affecting early drop-out rates among those who did not complete.

1.7.5 Addiction Studies, Stigma and Barriers to Treatment

Some of the findings from gambling studies are strikingly similar to those of current gender addiction research; chemically dependent women have been found to differ from their male counterparts, including patterns of drug use, psychosocial characteristics and physiological consequences of drug use (Halestine, 2000; Schober & Annis, 1996). Studies reveal that women are more likely to use drugs to cope with negative moods and start taking drugs at a later age with a ‘telescope’ effect attributed to womens psychological problems (Halestine, 2000). Useful insights can also be drawn from addiction studies regarding the role of stigma, since it is argued that negative attitudes persist about women with expectations for them to fulfil their role of homemaker, mother, carer, or employee. Sanders (2012) proposes that the emphasis on women’s reproductive roles contributes to a ‘double standard’ surrounding addiction, that women perceive as unique to them compared with their male counterparts.

There is some evidence that this is also true of female problem gamblers. In Israel, a qualitative study investigated the control exhibited by female problem gamblers (Gavriel-Fried, & Ajzenstadt, 2012). A cohort of seventeen women between the ages of thirty-one and sixty-

seven who were undergoing treatment at outpatient gambling addiction centres undertook semi-structured interviews. Four were childless, thirteen were mothers and four were also grandmothers. The study found that women who were problem gamblers made rational choices to help them juggle between their gender roles and gambling in order to minimise social costs that may be incurred by their gambling habit, highlighting how decisions and choices made by women were shaped by socio-cultural context. Limitations included a small participant pool and an imbalance among those who were mothers. The sample was not representative of the population at large since all participants were undergoing treatment. The study was carried out in Israel and therefore provides a picture of women in Israeli society. In addition, self-reporting and social pressure create potential bias. Cultural beliefs and values have been found to affect not only individuals' gambling behaviours but also help-seeking attitudes and utilisation of treatment and other health care services (McMillen, Marshall, Murphy, Lorenzen, & Waugh, 2004; Raylu & Oei, 2004). One study proposed that women may be motivated to stop gambling to resume their cultural role of caretaking and relationship tending, in other words to carry out their 'feminine prescribed role' (Avery & Davis, 2008). This quantitative study investigated a non-clinical sample of women who had achieved six months abstinence from gambling using a seventy-nine item online survey. Limitations included that the sample was cross-sectional, all measures were retrospective and self-reported, a convenience sample from the internet was used, and the criteria of six months abstinence could be considered too short to assume recovery. Therefore results cannot be generalised to all women. However, findings highlight the role of context and cultural norms in dictating perceived consequences of problematic behaviour such as 'problem gambling'.

Research has also identified barriers to seeking treatment for female problem gamblers. A literature review reporting on findings of nineteen studies in five countries found the most commonly reported barriers were: the wish to handle problem by oneself; shame/embarrassment/stigma; unwillingness to admit problem; and issues with treatment itself (Suurvali et al., 2009). Other frequently reported barriers include lack of knowledge about treatment options and practical issues around attending treatment. Women coming forward to ask for help have twice the amount of difficulties in terms of emotional, psychological and social blocks in doing so (Karter, 2013). Gainsbury, Hing and Suhonen, (2014) investigated awareness of professional sources of help and help-seeking behaviour amongst regular and problem gamblers. They recruited 730 Australian gamblers from the gambling population and used surveys to measure awareness of services, help-seeking behaviour, motivators and barriers to seeking help. They found significant barriers related to denial of the problem severity

and concern to access low cost services, arguing that public education should aim to 'de-mystify the treatment process and educate gamblers about symptoms of problem gambling to reduce shame, stigma and denial and encourage help-seeking' (Gainsbury et al., 2014. P 503). Limitations were that the research lacked generalisability due to numbers. Participants were provided with a list of barriers, motivators and treatment options for help-seeking which may have prompted participants, eliciting high levels of agreement with options rather than free response. In addition this did not look at gender-specific similarities or differences. An earlier study by Crisp et al. (2000) investigated sex differences in the treatment of 1,520 problem gamblers in Australia and proposed that services should be community-based and located in existing agencies to make it possible for women with dependent children to attend treatment. As online support services are becoming increasingly prevalent, recent studies have investigated the service delivery of online problem gambling services (Wood & Griffiths, 2007b; Rodda & Lubman, 2013; Rodda, Lubman, Dowling, & Jackson, 2013), finding that online support services appeared to be more favoured by women than any other service. One explanation for these findings could be accessibility as these types of services aim to address barriers to treatment such as shame and stigma, geographic isolation and hours of operation (Rodda & Lubman, 2013). This research is still in its infancy but could serve to inform treatment providers of useful means to engage hidden populations and hard to reach problem gamblers who need help.

1.7.6 Summary of Literature Review

Thirty-eight studies have been reviewed and critically appraised within the 'literature review' section. Of those papers, only eight were qualitative and thirty were quantitative. Four were from the UK, twelve were from the US, thirteen from Australia, five from Canada, one from Sweden, one from Spain, one from Denmark and one from Israel. Taken together, these studies demonstrate a recent shift towards gender differences in problem gambling; however, until recently research has been dominated by male samples and therefore are susceptible to male bias resulting in a deficiency in knowledge regarding women with gambling problems. The reviewed studies are limited in their scope, methodologically flawed, and few qualitative studies exist. Older studies tended to focus on women's gambling behaviour, were quantitative and based on surveys. Yet quantitative research cannot clarify reasons and motives in an in depth manner. In order to understand how female problem gamblers themselves view their treatment experience, a qualitative approach may be more useful. Other common limitations were generalisability; the results from most of the studies could not be generalised to all female

problem gamblers or to the UK population, since research indicates different presentations for different populations and gambling types. Many of the studies presented relied on self-report, which is vulnerable to weaknesses, including faulty memory, factual errors and self-presentation biases. Not many studies take into account types of gambling. Another area that was not addressed was the role of the therapeutic relationship which has been shown to be a predictor of treatment outcome in problem gambling therapy, as well as an active agent of change behaviour. (Smith, Thomas, & Jackson, 2004; Dowling & Cosic, 2010). Further research on this aspect of treatment for women could be beneficial.

1.8 Rationale for Study and Relevance for Counselling Psychology

Research and gambling prevalence studies indicate that rising numbers of women are participating in gambling activities and reporting gambling related problems. Furthermore, poor uptake of treatment by women at the [redacted], which has commissioned this study, highlights the vital need for a qualitative study which will address gaps in the literature. This small scale study aims to identify some of the unique needs of female problem gamblers so as to improve service delivery and develop new treatment programmes to reduce attrition rates and increase cost savings. Given the lack of theoretical integration in the field, an exploratory approach which considers 'the experience of treatment for female problem gamblers' seems likely to yield valuable insights for future investigation. First-hand accounts from women can be combined and collated with information from previous studies to devise new ways of reaching and engaging this population. With new information, Counselling Psychologists should be well-placed to deliver effective interventions to female problem gamblers, yet this cannot be done without an appropriate research base. Counselling Psychology considers, appreciates and values difference, diversity and the uniqueness of subjective experience (Rafalin, 2010), which existing research indicates is a prerequisite in working with this population. In addition, this study could inform policy makers about gambling laws, making innovative contributions to society, which could aid prevention. Milton encourages practitioners to appreciate the contribution that Counselling Psychology makes to the wider world, not just in the consulting room (Milton, 2010). This timely and important piece of research could therefore be a 'route to transformative change' (Milton, 2010).

CHAPTER 2 - METHODOLOGY

2.1 Methodology and Procedures

In this chapter, I will discuss qualitative research in more depth, examining Interpretative Phenomenological Analysis (IPA) and its epistemological underpinnings. I will comment on my own epistemological and personal position within the research and will subsequently consider the validity of IPA, placing the research in the context of Counselling Psychology, describing how and why this piece of work is relevant to the field. Following this I will state the practical details of the study, including participant recruitment; the procedure of constructing the interview schedule; interview and debriefing phases, and analytic strategy. I will relay my ethical standards throughout and will later comment on methodological reflexivity and limitations of the study[1].

2.2 Research Aims

The purpose of this study is to explore the lived experience of female problem gamblers who have received treatment for their problem. I wished to gain access to the meanings participants attributed to the specific process of seeking and receiving treatment and an understanding of their overall treatment experience. It was my intention that this thesis would not only benefit professionals, but also male and female problem gamblers, by offering an insight into the intricacies of the treatment journey for women. Hopefully one outcome would be to enable professionals to appreciate helpful and unhelpful aspects relating to treatment, in order to aid their own development and practice. I hoped that more effective future methods of treatment and ways to reach this population could be identified from the participants' narratives. On a macro scale, it was also my intention to generate useful knowledge for the National Health Service (NHS), as the field of Counselling Psychology seeks to enhance its profile within the public sector.

[1] *I use the first person in this text to reflect recognition within phenomenological psychology of the importance of the researcher in the research process.*

2.2.1 Research Question

- How do women experience treatment for problem gambling?

In addition, I also hope that my research findings will address the following questions:

- What factors are impacting on the experience of treatment for women seeking help?
- What are the treatment needs of female problem gamblers?
- What are the barriers to seeking help for female problem gamblers, if any?

2.2.3 Qualitative Design of Research

A qualitative approach was adopted for this exploratory study, in order to remain consistent with the research aims and to take into account the complexity of participants' worldview. Qualitative research is the interpretive study of a specific issue or problem in which the researcher is central to that sense which is made (Banister, Burman. Parker, Taylor, & Tindall, 1994, p.2). Qualitative researchers are concerned with the quality and texture of experience, rather than with the identification of cause–effect relationships (Willig & Stainton-Rogers, 2008). It enables in-depth investigation into 'complexities and processes' (Marshall & Rossman, 1989, p.46) rejecting the positivist notion that the world is unitary, single and real, and instead proposing each person interprets events differently (Pidgeon & Henwood, 1993), acknowledging the influence of the social and physical world. Qualitative findings are generally presented in everyday language and often use participants' own words to describe a psychological event, experience or phenomenon (Taylor & Bogdan, 1998, p. 128, cited in Ponterotto, 2005). With its focus on personal experiences and meanings, qualitative research aims to 'give voice' to otherwise unheard populations and in this way was deemed an appropriate methodological choice since it may support service users. Specific characteristics of qualitative methods are dependent on the research paradigm underpinning the enquiry. The lack of existing qualitative research in problem gambling, treatment for problem gambling and an even greater gap in literature on female problem gamblers as highlighted in the introduction, further justifies this methodological choice.

2.2.4 Relevance of Study to Counselling Psychology

The qualitative paradigm corresponds with the ethos of Counselling Psychology in several ways which I shall highlight. Based on humanistic principals (Rogers, 1961), Counselling Psychology aims to attend to individuals' unique experiences, setting out to appreciate diversity of experience and context. In this way it is concerned with the individual's subjective experience, appreciating the complexity of difference and focusing on wellbeing rather than just a cure (Rafalin, 2010). For both Counselling Psychology and qualitative research, the nature of the alliance, or relationship is at the heart of the process. Therapists and researchers must both negotiate levels of participation with their clients / respondents and the nature of their reciprocal roles (Bor & Watts, 2011). Neither assume 'expert knowledge', but instead seek to understand how a phenomenon is experienced through cooperative enquiry and by empowering clients or participants. In this way, the process of disentangling intersubjectivity and objectivity begins. Kasket (2012) highlights aspects of research which draw parallels with Counselling Psychology, including informed consent, transparency and continued participation involvement; all of which are demonstrated in this study. Overall close interpersonal contact was sought with participants, using face to face, participant led interviews, which facilitated the opportunity to build rapport. I see this as being as fundamental in gathering data as it is in therapeutic work. A qualitative approach seemed a natural fit and skills I have acquired from training were deemed transferable for aspects of the research, enabling me to adopt a holistic perspective to engage and embrace the whole person.

The study is also motivated by an interest and desire to increase the participation of the field of Counselling Psychology within the NHS, in line with the Agenda for Change agreement of 2004, which sought to create employment opportunities based on shared occupational grouping. I hope this study will go some way towards demonstrating how Counselling Psychologists can work in the NHS, as well as showing what the potential value and benefit of Counselling Psychologists within NHS practices could be. I believe it is time to move away from arguments around what our identity is and instead towards establishing a means of integrating our skillset into practices (Watkins, 1985). This surely can only be achieved through demonstrable evidence of our skills. As McLeod (2003) highlights, research is a can enable the practitioner's perspective to be broadened, allowing work experience to be shared and knowledge accumulated. Milton (2006) poses the question as to whether Counselling Psychologists can effectively integrate with other disciplines and colleagues. I hope research from our field can provide evidence of how this is possible. Barker, Pistrang and Elliot, (2002) suggest research can satisfy curiosity, personal curiosity, professional and social change,

competition, institutional demands, all of which go some way to explain the motivation for this research and its relevance to Counselling Psychology.

2.3 Overview of Interpretative Phenomenological Analysis and Philosophical Underpinnings

In this next section I will describe the philosophical and theoretical commitments which are inherent in IPA, considering why this general approach was selected to investigate the research question. IPA was developed by Jonathan Smith in 1996 as a means to revive a more pluralistic psychology that could capture subjective and experiential accounts grounded in psychological enquiry. Whilst this qualitative approach was initially popular in health psychology, IPA has since been increasingly taken up in clinical, counselling, social and educational psychology (Smith, Flowers, & Larkin, 2009), demonstrating its increasing acceptance, applicability and relevance. The main theoretical underpinnings of IPA are phenomenology (Moran, 2000), hermeneutics (Palmer, 1969) and ideography (Smith, 1995) which will be described below. IPA was deemed a suitable methodology for this study due to its commitment to the examination of personal lived experience, encompassing the meaning of the experience being investigated to the participant and how the participant makes sense of this experience. In other words it sees 'people as meaning makers', relating to its underpinnings of phenomenology and hermeneutics, which will be described below. This relativist approach, with its acknowledgement of diversity of interpretations (Willig, 2001, p.13), has the potential to provide an 'insider's perspective' if conducted with commitment and care, through exploration, understanding and communication of the experiences and viewpoints offered by participants (Larkin et al., 2006). This correlates with the study's aim to understand the individual experiences for female problem gamblers who have received treatment at the [redacted]

2.3.1 Phenomenology

Phenomenology encompasses a philosophical movement that includes a range of research methods. The phenomenological aspect of IPA is concerned with methods which facilitate the examination and illumination of detailed accounts of types of lived experience. This is not just a descriptive account, but more of an interpretive one, in that it recognises the role of 'the other', unlike Husserl's original, descriptive concept of phenomenology in the early 20th

century. Described as an 'armchair philosopher', he argued that human experience forms the basis of what is known, and that we should therefore 'go back to the things themselves' by adopting a phenomenological attitude and shifting our gaze inwards, away from external objects. He proposed the process of the epoché (1967) which is also described as the 'reduction' or '*bracketing*' as a means to gain access to the meanings or 'essence' of any given phenomenon, moving away from description of individual experience which may be clouded by our own assumptions, to the description of the structures of experience more generally. Across his writings Husserl conceived a number of different epochés, including the natural attitude and the transcendental reduction. These complex ideas, which were supported by Giorgi (1985) seem to highlight how a phenomenological attitude entails looking at things in a different way, rather than taking them for granted, and doing this mindfully, with some awareness[2].

Moving away from Husserl's transcendental approach, existential phenomenologists sought to address ontological questions about existence and being. This movement, led by Heidegger, Sartre and Merleau-Ponty, resulted in a radical transformation of phenomenological philosophy, which acknowledged that reduction cannot always be made since our observations are made from our own biased position. Heidegger's hermeneutic proposition viewed the person as always a 'worldly person in context', highlighting the shared, overlapping and relational nature of our engagement with the world, in that we are part of a meaningful world, which is also part of us. This fundamental rejection of the Cartesian divide between subject and object is captured by Heidegger's characterization of human-being in terms of Dasein, or being 'always somewhere' (Larkin, Watts, & Clifton., 2006). Merleau-Ponty (1962) took this contextualised idea further, emphasising the embodied nature of our relationship with the world, the need to account for the body and understanding the person as a body-subject, with consciousness always embedded in the body. This idea of our body being the primary site of knowing in the world and that the body cannot be disentangled from that which is perceived, is critical for IPA researchers. Sartre stressed that existence comes before essence and also emphasised the existence of social, historical and contextual influences on the lifeworld (Eatough & Smith, 2008). These ideas are central to IPA's take on phenomenology which

[2] *Adopting a phenomenological attitude is a vital part of the research process, which I will continue to describe in the proceeding chapters, however IPA is more modest that Husserl's epoché, in that it attempts to capture particular experiences as experienced by particular people*

acknowledges that an individual's experience cannot be accessed directly but that the best we can do is to attempt to understand an experience by investigating how it is experienced and given meaning by an individual (Eatough & Smith, 2008; Smith, 1996). In other words, access to experience is 'partial and complex' (Smith, 1996) and any account is always constructed by the participant and researcher (Larkin et al., 2006).

2.3.2 Hermeneutics

IPA is also influenced by hermeneutics, or the study of interpretation. Encompassing the study of written texts and the role of the researcher attempting to make sense of an individual's narrative, hermeneutics provides important theoretical insights for IPA. Prominent hermeneutic theorists whose ideas I will draw on throughout the analysis stage of this project include Ricoeur, Schleiermarcher, Gadamer and Heidegger. Larkin proposes an interpretive analysis can be developed by positioning the initial description provided by the participant in relation to a wider social, cultural and theoretical context; this provides some space for the researcher to be speculative (Larkin et al., 2006).

While there are different interpretative stances available to the researcher, IPA tends to combine empathic hermeneutics with suspicious hermeneutics, attempting to understand what it is like for the participant whilst asking critical questions of the textual account. Ricoeur (1970) proposed combining the two for a richer analysis and to take into account the totality of the person. Schleiermacher proposed that interpretation involves both grammatical and psychological elements; in other words that there can be hidden meanings or insights beneath the surface waiting to be discovered, which may subsume the explicit claims of participants (Smith et al., 2009, p.23). Meanwhile Gadamer highlighted the hermeneutic process, emphasising the active historical / cultural situatedness of all understanding and the complex relationship between the interpreter and the interpreted. He reminds us that 'foreunderstandings' will continually be revised in the light of new understandings of the phenomenon'. This alludes to Heidegger's influential hermeneutic circle, which illustrates the dynamic relationship between 'the part' and 'the whole'. It purports that one's understanding of text as a 'whole' is established by reference to 'individual' parts, and that to understand any given 'part' one must look to the 'whole'. Like IPA, it emphasises the researcher playing an active role, which can be complicated by their own viewpoint. The dual role of the researcher is illustrated by a double hermeneutic with the researcher trying to make sense of the participant trying to make sense of their experience (Smith & Osborn, 2008.) In this way,

interpretations are recognised as being dependent on the participants' ability to articulate their thoughts and experiences and the researcher's ability to reflect and analyse; therefore findings are acknowledged as a co-construction between participant and researcher (Osborn & Smith, 1998, p. 67).

2.3.3 Idiography

Idiography is the third major and distinctive influence of IPA, which is concerned with the particular, in contrast to the dominant nomothetic approach found in traditional psychology that attempts to establish general laws of human behaviour. This ideographic mode of enquiry aims to understand each individual case, emphasising the subjective way that individuals make sense of their experience (Smith, 2004), rather than making generalisations. IPA's commitment to the particular is through detailed, thorough and systematic and in depth analysis. Secondly by understanding how particular experiential phenomena have been understood it tends to concentrate on specific individuals as they deal with specific situations or events in their lives (Smith, 1999). In other words, IPA is committed to the individual case and looks for similarities and differences. By understanding one account first, the researcher will subsequently be informed of further accounts of the same experience and may then gain an understanding of a more general experience. In this way IPA findings can shed light on existing nomothetic research and therefore has 'theoretical transferability' (Smith et al., 2009, p.38). The value of IPA is that it can offer 'detailed, nuanced analyses of particular instances of lived experience' (Smith et al., 2009, p.37).

2.4 Epistemological Standpoint

IPA does not claim a distinctive epistemological position but was developed from a broad base of theoretical influences including phenomenology (Moran, 2000), symbolic interactionism (Blumer, 1969), social cognition (Smith, 1996) and social constructionism (Burr, 2003). As such, it is characterised by epistemological 'openness' (Larkin et al., 2006). My own stance in relation to IPA in the current work constitutes an attempt to join a critical realist perspective with a contextual constructionist epistemology.

Critical realism (Bhaskar, 1978) is a realist approach which accepts that there are stable and enduring features of reality that exist independently of human conceptualisation (Willig & Stainton-Rogers, 2008), but also acknowledges an inherent subjectivity in the production of

knowledge (Madill et al., 2000). Differences in the meanings individuals attach to experiences are considered possible because they experience different parts of reality. Critical realism contends that "the way we perceive facts, particularly in the social realm, depends partly upon our beliefs and expectations" (Bunge, 1993, p.231). Critical realists assume that participant data can therefore tell us about reality although they do not view this as a direct mirroring (Harper, 2012).

IPA can be said to be consistent with a critical realist stance in that IPA assumes that people's accounts tell us something about their private thoughts and feelings, which in turn are conveyed through people's experiences. According to IPA, participants can experience and make sense of the same 'objective' conditions (e.g. their treatment experience for a gambling disorder) in radically different ways because such experience is shaped by the thoughts, beliefs, expectations and judgements that the individual attributes to it (Willig & Stainton-Rogers, 2008). This perspective is in accordance with the philosophical assumptions of IPA, as this research will look at how these female participants are making sense of their experiences, rather than to try to find out if they are true or false, or externally valid. The critical realist approach adopted by IPA is also consistent with my decision to interview participants who had undergone CBT, which purports that the same experience can have many different interpretations and therefore affect individuals in different ways.

My epistemological position is based on a 'contextual constructionism' (Madill, Jordan, & Shirley, 2000), which acknowledges that it is not possible to remove ourselves, our thoughts and our meaning systems from the world, in order to definitively find out how things actually are (Larkin et al., 2006, p. 107). Contextual constructionism is based on the supposition that all knowledge is local, provisional and situation dependent (Jaeger & Rosnow, 1988, cited in Madill et al., 2000). It therefore contends that results vary according to the context in which the data is collected and analysed. In this way, as with critical realism, different viewpoints can provide different understandings of the same phenomenon (Willig, 2001).

As a researcher, I recognise it is not possible to directly discover the realities of my participants, since my own understanding will be influenced by my experiences and my own views and I myself am an inclusive part of the world I am describing. A contextual perspective acknowledges that the researcher will bring her own personal and cultural standpoints when conducting research (Madill et al., 2000). The implications for research are that discoveries that are made must in some way be 'a function of the relationship that pertains between

researcher and subject matter' (Larkin et al., 2006). In this way my findings will be dependent upon the relationship I have with my participants, so I feel it is essential that this relationship should be explored, this I will aim to do in reflexivity throughout the research, so as to avoid a credibility problem.

To summarise, this research is allied with moderate contextual constructionism, and anchored by critical realism. This could be described as taking a position somewhere between realist claims that results emerge directly from the data, and relativist claims that experience always involves an interpretative activity (Madill et al., 2000). As a researcher, I accept that it is not possible fully and directly to access my participants' experiences. Instead I am focusing on the 'person-in-context', who is embedded within a social, cultural and historical reality. Since understanding of experience involves a process of interpretation, I will endeavour to consider my own relatedness to the topic and data and be prepared to adjust my own ideas and assumptions in response to the promptings of the subject matter (Larkin et al., 2006). In doing so I hope to illuminate how participants understand and make sense of their experiences of self.

2.4.1 Epistemology and Personal Reflexivity

Reflexivity is a vital part of qualitative research that requires an awareness of the researcher's own contribution to the way in which meanings are constructed throughout the research process and an acknowledgement that, due to our own circumstances and history, it is impossible to stay outside of the subject matter during the research process. Reflexivity urges us to explore the ways in which a researcher's involvement with a particular study 'influences, acts upon and informs such research' (Nightingale and Cromby 1999).

Through reflections on my own position within the research, a predominant issue has been my own relationship with the [redacted] where I had a clinical placement[3]. Questions including; how would I feel about going into [redacted] to conduct research? How would my own experience of working in [redacted] and my knowledge of the treatment pathway affect my interpretations? How would my relationships with colleagues and management impact on my own agenda and

[3] *It is important to note that while I was still on placement at the* [redacted] *at the time of my research, I did not treat any of the women participants as clients and had never met them before undertaking the research.*

expectations? Despite this being an independent research project, would the research impact on my clinical work? How would I balance my position as a researcher, as a therapist and as a woman? How could I use selected Counselling Psychology skills such as listening and warmth, while managing temptation to intervene or reflect things back with my own language? How would previous encounters with clients at the clinic impact on my assumptions about participants in my research? How would I impact upon my participants' propensities to talk openly? Would they see me as an expert or be intimidated? Should I be open about my role at the clinic as a practitioner? Would they assume I had any links with the clinic? Or would they be able to talk openly? These were some of the queries I had.

Having never experienced a gambling problem personally, this was a new area for me when I started the placement. Previously I associated gambling with my grandfather, who was a social gambler and taught my sister and me to play cards for money when we were very young. Twenty-five years later, my sister (like many other women) enjoys the privacy and anonymity of gambling on her mobile phone. This placement illuminated how easy it can be to slip into problem gambling territory with devastating consequences. While in some ways I felt that not having experienced a gambling problem or treatment may help to remove me from emotional bias or attachment to the issue during the research process, this detachment left a gap for other biases, such as assumptions from what I have heard in the media, or my experiences working clinically with people with gambling disorders. In other words it is impossible to remain entirely detached. As I progressed, several processes occurred. I became aware of how gambling urges and cravings overlapped with some of my own experiences; I had an insecure attachment and could relate to some of the thoughts, feelings and compulsive behaviour often described by problem gamblers in treatment, although my own 'urges' were in a more relational context. Perhaps this was one of the aspects that drew me into the area with an interest to specialise in it. Another major shift was that as I formed relationships and attachments with clients, learning more about the gambling industry and the widespread surrounding problems, I became passionate about the topic on their behalf. My attention has become increasingly captured by the growing volume of media coverage further highlighting the issue. So in numerous ways, my experience at the clinic has affected the way in which this study was conducted, including the interpretation and presentation of the data. As the research progressed, I have made other valuable contacts, for example at GamCare and international gambling treatment agencies, whom I have discussed the issue of women in treatment with, continuing to gather more information and ideas, which in turn affects my stance. I have also joined a recently formed international network of professionals who are also interested in this

topic. Another valuable way of gaining exposure and feedback for my proposal was through a poster submission at the Counselling Psychology Annual Conference 2014, which won first prize (See Appendix P). Here I incorporated feedback into my research that one interview per participant would suffice. As the only gambling-related submission at the event, I became more aware of the gap for this particular topic and the importance of furthering knowledge in the field.

Careful consideration will need to be paid to these personal and epistemological queries. I will need to consider my own values, experiences, interests, beliefs, political commitments, social identity and wider aims of this research before, during and after the research process. Therefore I attempted to be open to my experiences from the outset in my reflexive diary and frequently discuss my thoughts and to consider ways in which the research may have changed me as a person and as a researcher, in supervision and through personal therapy.

2.4.2 Epistemological Reflexivity

Epistemological reflexivity enables an exploration of the ways in which the research has been influenced and shaped by wider influences. It is important to acknowledge that the research question and method of analysis defined and limited what could be known and to some extent constructed the data and findings. This process has required continued reflection on my personal assumptions about knowledge, what can be known as well as my assumptions about the world.

There have been epistemological tensions throughout the research process; one of the aims of the research was to reflect the participants' reality of their experiences whilst also advocating myself (as researcher) to be active in constructing the meaning from their account. One of the major criticisms of IPA that despite trying to gain access to meaning, it is not possible to read people's thoughts and cognitions and therefore we rely on people's ability to explain, to be honest and like an open book. Yet the research questions, the interview schedule, the participants' understanding and ability to describe, and our relationship with each other as well as means to construct meaning through interpretation, are all factors that can limit this. Pidgeon and Henwood (1997) identify four dimensions which may impact on the knowledge produced: 1) Participants' own understanding 2) researchers' interpretations 3) cultural meaning systems which inform both participants and researcher 4) acts of judging particular interpretations as valid by scientific communities (p. 250).

Larkin et al. (2006) further suggest that given these inherent constraints, the researcher must demonstrate 'sensitivity and responsivity' in attempting to reveal the 'pure' experience of participants. Reflections on such limitations and tensions can be found throughout, as well as in methodological and procedural reflexivity sections.

One such reflection I shall make here: My research aim was to gain a better understanding of female problem gamblers' experience of treatment at the [redacted]. However I had considered investigating the research question differently, for example looking at how social processes were impacting on this experience. During the early stages of my proposal I considered exploring 'the role that being a woman played in the experience of treatment'. With a background in sociology this was a tempting question to address, as referral and attendance data from the [redacted] suggests there is a gendered affect, however on further consideration this social constructionist approach felt too restricting with its underlying assumptions. I decided this question risked failing to address what was at the heart of my study; to gain a richer understanding of the treatment experience itself, rather than shifting the main focus onto social processes and gender literature. Since this is a new area for research, with no other UK studies that have focused on female problem gamblers in treatment, it seemed useful to start with a more open enquiry that sought to understand this phenomenon for each individual, without imposing pre-existing frameworks of meaning in order to discern its essence. The implications for potential research findings felt more applicable to a broader audience and it seemed a solid initial research question, although this further highlights the limitations and tensions inherent within my research question.

2.5 Validity and Reliability

Qualitative research has attracted numerous debates around validity and reliability, with the main issues being around how research should be evaluated without enforcing prescriptive methods and the effect of the individual analyst on research findings. In her paper entitled *Quality and Trustworthiness in Qualitative Research in Counselling Psychology*, Morrow (2005) proposes that standards appropriate for evaluating studies vary according to the paradigmatic underpinnings of the research and the standards of the discipline. This seems important since qualitative research is not a homogenous field, but there are a number of epistemological positions within which the researcher can work. Therefore a more sophisticated and pluralistic stance which can be applied to different theoretical orientations seems useful.

Yardley (2008) suggests four key dimensions by which studies using qualitative methods can be assessed: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. These broad principles are proposed as a guideline in considering the validity for the current research study and IPA in general and I outline below ways in which they have been addressed within the present study.

The first core principle outlined by Yardley is sensitivity to context. This is relevant throughout the entire research process, from the literature review – to the data collection and analysis (Yardley, 2008). This study aims to address a gap in the current research on female problem gamblers with its specific focus on treatment experiences of this particular group. A thorough literature review can be found in Chapter One demonstrating the rationale and development of the research questions and acknowledging existing theory. Sensitivity to the perspective and socio-cultural context of participants is also important (Yardley, 2008) with IPA being selected in part for its potential to elicit the perspective of each participant with its focus on the particular and therefore implicit sensitivity. The interactional nature of the interview situation is another way in which sensitivity is demonstrated.

Participants were offered the opportunity to meet at the gambling clinic, where they had already received treatment, or in their own homes in order to ensure that they felt entirely comfortable throughout the interview process. In addition, the interviews were carried out by myself – a woman. It was hoped these factors might encourage the women to give an open and honest account of their experience. Furthermore, the interview schedule (see Appendix C) was constructed with open-ended questions to encourage participants to convey what was important to them regarding the topic with minimal influence from myself. The issue of sensitivity was also considered at the analysis and writing up stage with reflection upon the content of the women's views and how these were expressed.

A second principle is that of commitment and rigour (Yardley, 2008). Personal commitment and investment has been necessary throughout the research process to attend to participants' needs, for example being flexible and accommodating timings and locations for meetings. For rigour, sufficient depth and therefore thoroughness of the study is essential and insight should be demonstrated in terms of the analysis. While I have endeavoured to engage with the women's narratives extensively, assessment of the study will also lie with the reader. Another aspect of this issue is that of the sample, which is discussed in more detail, with a coherent

rationale below. However it should be noted that time constraints were taken into account and the study was designed with these limitations in mind.

The third issue is that of coherence and transparency. Coherence may be described as being between the design of the study and the analysis and presentation of the data; it relates to how much the study makes sense as a consistent whole (Yardley, 2008). Data analysis, interpretation and writing has been a continuous, iterative process, rather than a linear one. I have been mindful of this throughout the research process but the reader can evaluate.

Transparency relates to how clearly the reader can see exactly what has been done and why (Yardley, 2008). I have endeavoured to make the aims of the research and research questions clear and have also provided a detailed description of the design and procedures employed in the research process that is fully referenced to a body of literature. Attention has also been paid to reporting the divergent experiences that contradict the emerging patterns of themes within the women's accounts (Meyrick, 2006). This aim is to demonstrate the process of "disconfirming case analysis" (Yardley, 2008, p.242) rather than simply presenting that which fits with my perspective. Importantly, the entire process is supported by a full 'paper trail', from initial documentation to the final report, to provide a means to check the data and so that each step of the analytic process may be traced in detail. (Yin, 1989; Yardley, 2008).

In addition, transparency is enhanced through reflexivity. Rennie (2004) cited in Morrow (2000, p.183) defined reflexivity as 'self-awareness and agency with self-awareness'. I have endeavoured to demonstrate this in a number of ways throughout the report, for example, I have kept a self-reflective journal from inception to completion of the investigation. In it I have recorded my own experiences, reactions and emerging awareness of any assumptions or biases. I have also consulted with my supervisor and research team at the [redacted] on a regular basis. Rallis (2003) cited in Morrow (2000) recommended using the 'community of practice' made up of knowledgeable colleagues to engage in 'critical and sustained discussion'.

The final issue in validity is that of impact and importance (Yardley, 2008). Meaning, context and complexity of this group of women's lived experience of treatment for problem gambling is the main focus and as such a rich, contextual and interpretative description of their subjective experience has been generated. I hope this will provide a better understanding of this particular group of women for Counselling Psychologists so as to improve clinical practice. It is also hoped that on a wider scale, service delivery will be improved and new programmes will be

developed to reduce attrition rates and increase cost savings. In addition this study could inform policy makers about gambling and advertising laws making innovative contributions to society which could aid prevention.

2.6 Procedure

2.6.1 Sampling and Participants

This study used purposive sampling as the aim was to explore and gain insight into a particular experience. Smith et al. (2009) propose that researchers conducting IPA should aim to find a homogeneous sample in order to facilitate a detailed examination of psychological variability of the convergences and divergences which may arise within the sample. Eight participants were interviewed from the [redacted], all of whom were women who had either completed treatment or were in the final two sessions therapy (last quarter), so as to reduce the possibility of interfering with therapy outcome. Smith and Osborn (2003) suggest between five to ten interviews, to enable detailed analysis. In accordance with these principles and taking into account time and financial constraints, eight participants were deemed appropriate for a sufficient and manageable amount of information to be extracted. All potential participants gave expressed permission to be contacted for research purposes during their initial assessment for treatment. Participants were recruited according to the clinic's research protocol, which included an initial telephone screening by myself to ensure suitability (see Appendix D). Screening questions included date of birth to ascertain whether they fit the inclusion criteria in addition to address, to ascertain whether it would be possible to arrange a face-to-face interview since the clinic is the only NHS clinic in the UK and some clients may live far away. A Patient Health Questionnaire (PHQ-9) was used as a screening tool, and participants who scored above 20, which indicates depression is present, were eliminated to avoid causing distress. The initial plan was to interview each participant twice, in order to gain richer data and to enhance rapport with participants. This was later amended as I came to understand that multiple interviews are more common in IPA if a particular phenomenon or experience over time is being investigated. Therefore it was deemed suitable for each participant to be interviewed only once. Details are discussed in the participant recruitment section below.

In short, principal inclusion criteria for this study were that participants were female, were between the ages of eighteen and seventy; this was because the clinic only treats adults (18 plus) and during my time at the clinic, the oldest adult I worked with was 63 years old. I decided

to cut off at 70 in case to decrease the chance of any age related co-morbidities and in particular memory impairment. Participants were required to have completed treatment within a year, or approaching the end of their treatment at the [redacted] and to be capable of giving written consent to participate. In addition participants should have been willing to be interviewed for approximately 90 minutes and willing to share their experiences of treatment and aspects of their gambling behaviour. Participants who had received individual face-to-face or remote CBT were selected, since this is currently the main mode of therapy at the [redacted].

Exclusion criteria for the population were anyone who did not fall into the criteria above or anyone who did not speak English as a first language. It was deemed a necessary requirement that they spoke the same language as the researcher in order to eliminate the possibility of losing richness or complexity of data due to a language barrier, or having to recruit an interpreter which would add another level of interpretation. Additional exclusion criteria included any history or prevalence of neurological disorder or diagnosis of schizophrenia or bipolar. This was to keep the group as homogenous as possible and an attempt to capture the experience rather than the memory of the experience.

2.6.2 Pilot Interview

A pilot study can help test and refine one or more aspects of the final study (Kim, 2010). The first of the eight participants was recruited for a pilot interview. This participant was selected at random and happened to be the first participant who was available to meet me. After conducting the pilot, I realised my original interview schedule was too long and a few of the questions were unrelated to the main topic and even confusing for the participant, therefore after discussing this in supervision, the interview schedule was adjusted for the next participants. The relevant parts of the interview were later added into the data.

Table 2.1 below includes relevant information from the participants who took part in the study. Pseudonyms have replaced real names to ensure anonymity.

Table 2.1: Women who participated in study

Name	**Age**	**Type of problem gambling and location**	**Treatment Duration**	**Stage of Treatment**
Amy	41	Fruit machines, (pubs, arcades)	5 sessions	One week since completion

Alice	55	Fruit machines (arcades)	8 sessions (remote)	6 months since completion
Beth	42	Slots, roulette, poker (casinos, online)	9 sessions	One week since completion
Catherine	30	Fruit machines, (Arcades and online)	8 sessions	One month since completion
Diane	38	Slots (Online)	8 sessions	10 months since completion
Emma	35	Online	8 sessions	5 days since completion
Natalie	35	Roulette (Casino)	8 sessions	4 months since completion
Jacqui	40	Fruit Machine, (Casino, bookmakers)	6 sessions	In treatment, 2 remaining sessions

2.6.3 Participant Recruitment

The process of recruitment involved informal discussions with management at the [redacted]. I had good knowledge of the service as I had been on a placement prior to deciding to conduct my research in this area and was therefore aware of the paucity of female clients presenting for treatment and the high drop-out rates for females compared to males, as highlighted in the introduction section. The management team fully endorsed the study pending NHS ethical approval (see Appendix E for letter of support from [redacted]).

The [redacted] was deemed an ideal base to conduct this study as it represented the opportunity to target a hard to reach population directly. Given the paucity of the target population, there was a plan to contact other organisations such as GamCare if there were not enough willing female participants at the [redacted], however this was not necessary, as more women than expected were happy to take part. On reflection this could be because those women who had completed treatment who were targeted reported feeling that they wanted to give something back and help others by participating.

Recruitment for participants involved a standardised flyer, distributed to patients via the clinic staff (see Appendix F). In addition I was given a list of names and contact details of women who had agreed to participate in research at the time of their assessment. Where possible this took place at the [redacted] so that a clinical supervisor was on hand to debrief, and in case of any issues arising. If interest in the research was expressed, participant information sheets were distributed via email or post, reiterating information concerning the purpose of the study (see Appendix G)

Upon obtaining verbal participant consent, a mutually convenient time and location to meet with participants was agreed. The [redacted] was always suggested as a preferred venue, but if this was not convenient or possible for participants another suitable venue was agreed. Participants were reminded that the interview would be recorded.

2.6.4 Pre-Interview Discussion

Most interviews took place in a pre-booked treatment room at the [redacted]. Three interviews took place at participants' homes or mutually agreed venue as the women were unable to travel to the clinic due to financial or practical limitations. Upon meeting, participants were given a verbal explanation of the aim of the study, how the interviews would be used and the anticipated duration of the interview. The nature of their participation and the interview style was also discussed in order to ease any nerves; during this discussion, rapport was built to facilitate a comfortable interaction. For transparency, the nature of the research was explained. Specific analytical features or themes were omitted to avoid influencing thought or narratives. Participants were then given a consent form to sign (see Appendix H), offered a copy and reminded that they could terminate the interview or their participation at any time, or pause the recording. Participants were informed that their names would be changed for the study to ensure anonymity. Prior to the interview, participants were invited to ask any questions or express any concerns before being invited to begin. Interviews were recorded and took between 50 – 75 minutes with the participants' age and predicament taken into account. Participants were also asked whether any topics were off-limits to ensure sufficient boundaries were in place. A write-up of observations and my own reflections were completed following each interview.

2.6.5 The Interview Schedule

Smith and Osborn's guidelines for conducting semi-structured interviews for IPA were consulted prior to constructing the interview schedule. Designed to be collaborative in nature, emphasising the participants as primary experts and aiming to make them feel as comfortable as possible, the interview schedule started with a question that encouraged participants to recount a descriptive experience (see Appendix C).

The questions were open ended and served as a guide for possible areas to cover, rather than leading participants towards certain responses or imposing any views on them. This style of questioning should allow truth value to emerge – which is subject orientated, not defined a priori by the researcher (Lincoln & Guba, 1989). Space was left for participants to express their feelings openly and in detail (Alexander & Clare, 2004). Questions were asked about participants' experiences of treatment, their best and worst aspects of treatment, meanings they attributed to being in treatment as well as their perceptions of themselves and their gambling behaviour after treatment.

In order to aid the interaction and active listening, questions were memorised so as not to distract the participant with constant reference to it. Summaries of some responses were provided to ensure full understanding.

2.6.6 Post Interview Debrief

A verbal debrief was conducted after each interview, to allow participants the opportunity to discuss the study, or concerns, listen to the recordings in the presence of the interviewer or request a copy of the transcript or final research. Participants were given a debriefing form (see Appendix I). Since all participants completed their interviews no information needed to be destroyed. Upon completion of the interviews participants were presented with a £20 M&S gift voucher. Had any participant terminated the interview early they would have still received a voucher. After all interviews had been completed, they were subsequently transcribed and the data was analysed using IPA (see Analytic Strategy section). Finally, all findings were written up in this final thesis.

2.7 Ethics and Permissions

The proposal for this study was granted full ethical approval by the Department of Psychology at City University. The ethics release form may be found in Appendix J. The proposal was also granted full ethical approval by NHS ethics committee. The R&D Governance Approval letter can be found in Appendix K. In addition, full and due consideration was given to the ethical implications of the proposed research, in accordance with the British Psychological Society Code of Conduct, Ethical Principles and Guidelines (2014). The ethical considerations have been discussed throughout this chapter, but to re-iterate careful consideration was given throughout the research process with special measures in place to ensure participants'

wellbeing, confidentiality and anonymity. These included a supervised telephone screening, face-to-face interviews, a debriefing sheet with details of support organisations as well as contact details for researcher and supervisor contact details, reminder of right to withdraw and participant information sheet. Anonymity was guaranteed; all names and identifying information has been changed to ensure confidentiality and recordings and transcripts were encrypted and stored securely in a locked cabinet for five years, after which they will be destroyed in accordance with the BPS's ethical requirements. Participants were offered the opportunity to read a summary of results. A gift voucher incentive was given to participants at the end of the interview in order to demonstrate their time was valued. Careful consideration was given to offering a voucher rather than money due to nature of the research. For a reflexive discussion regarding relevant ethical issues, such as the interpretative nature of the research, please see the section on methodological and procedural reflexivity.

2.8 Transcription

Each interview was transcribed verbatim by the researcher. Attention was also paid to non-verbal behaviour such as gestures, laughter and long pauses (Smith & Dunworth, 2003). The transcripts included all false starts and extraneous words such as "umm" and "you know" to keep the transcript as consistent with the original dialogue as possible for the purposes of analysis. I attempted to immerse myself in the data during the transcription process so as to re-live the interview. All identifying information was changed at the time of the transcription in order to maintain anonymity. A document describing which participant corresponds to which pseudonym and transcript has been kept securely but separately from the research data in a locked cabinet and will be destroyed upon completion of the research.

2.9 Analytic Strategy

IPA seeks to understand the complexity and meaning of the participant's world via their narrative (Smith & Osborn, 2008). Analysis is described as an iterative and inductive cycle which involves flexibility and is expanded up until the stage of writing up; themes are constantly reworked and reorganised throughout this process (Smith et al 2013). Below I have described the analytic steps taken for the analysis of this study, although this illustrates my own personal way of working, and does not mean to imply that this is the only way to analyse.

As IPA approach is idiographic in nature (Smith & Osborn, 2008), the initial focus in the analysis was on the issues arising from each individual transcripts which were worked through one at a time. The transcripts were formatted in landscape with a wide margin on the left hand side and a smaller margin on the right hand side to allow for notes to be made. The lines were numbered as were the pages for ease of reference throughout the analysis.

Each transcript was read through carefully whilst interview recordings were simultaneously listened to as I immersed myself in the process. I found this enhanced the analysis as participants' voices and inflections could almost be heard mentally on subsequent readings (Smith & Dunworth, 2003). Notes regarding initial thoughts or points of significance about the transcript were made separately in another document, in order to bracket off my initial observations. Keeping an open mind, each transcription was then read several times and the right hand margin was used to make exploratory and descriptive notes on anything that was of interest. These notes included use of particular language styles, convergences or contradictions, summaries of the narrative, and some basic preliminary interpretations. The aim at this point was to stay close to the text and its meaning (Langdridge, 2007; Smith & Dunworth, 2003).

Following this, the left hand margin was used to develop initial notes and ideas into more specific themes, emphasising both convergence and divergence, commonality and nuance and marking a shift to a more interpretive process. The transcript was continually checked and revisited with careful attention paid to the connection between my interpretations and the participants' words to ensure emerging subthemes were embedded in the original text and therefore representative of the participant's narrative. It seemed vital to continuously verify my interpretation against the participant's original dialogue to ensure validity. When the table of themes was completed, the entire procedure was performed on the next transcript using the table of themes from previous analysis to guide subsequent analysis. Care was taken to remain open to new themes arising in subsequent transcripts and initial analyses were amended and checked as the analysis continued through participants. The process was therefore iterative (Langdridge, 2007).

Once a preliminary analysis had been performed on all of the transcripts, a further review of each spreadsheet was performed. The transcripts were revisited and all quotes were checked to ensure that they were fully representative of emerging themes. Supervision was used to check that my emerging themes could be linked back to the text. Throughout this cyclical and

iterative process, quotes that were not considered to fully represent the emerging themes were discarded and the clustering was reordered in light of the other analysis. This “sifting” through the data was a slow but steady process, which established a bigger picture of the entire data set. (See Appendix L for an extract from a transcript of the analysis where descriptive and interpretive comments are made).

The analysis was then performed across the cases. Each theme was compared and contrasted across participants. Connections between each participant’s theme tables were examined. A master table of themes was constructed that captured the important shared aspects of the women’s experience across the individual transcripts (Smith & Dunworth, 2003). The transcripts were revisited once again and each quote was re- checked to ensure it was truly representative of each theme. For each participant the most appropriate quote was chosen. As before, the table included theme, sub-theme, participant reference and the page and line references for each quote. (See Appendix M for an extract of a table of themes).

Subsequently the data was further reduced and clustered together in chunks using the ‘imaginary magnet’ technique (Smith 2004, p. 71, cited in Lyons & Cole 2007) to illustrate the relationship between themes. Post-it notes were used to assist with this process. Transcripts were also checked for oppositional relationships between emergent themes by focusing on difference rather than similarity. Connections were also sought between emergent themes and context, as well as considering their specific functions within the transcript. Once it was felt that saturation or gestalt had been achieved and that all patterns had been explored, a table was produced (Appendix N) highlighting labelled master themes that represented the entire data set that could also act as an independent audit (Smith & Osborn, 2003). At this stage the final decision was made regarding what to include in the write-up.

Throughout this process the participants’ accounts were carefully attended to with the aim of keeping their account in the foreground with psychological theory being drawn out only when triggered by a personal account (Smith, 2004). Supervision was used to help test the coherence and plausibility of interpretations. The process of analysis is subjective on the part of the researcher so my aim was to be aware of my own conceptions as well as those of my participants’ and to define them clearly throughout. This was achieved by revisiting contents of the transcripts and making consistent use of supervision. I also followed Silverman’s (2000) recommendations to keep a research diary in order to record thoughts and ideas and to maintain a reflective stance. A brief extract of the reflective diary can be found in Appendix O.

2.10 Methodological and Procedural Reflexivity

My first reflection concerns the analysis of the data. I recognise that at times, the analysis has incorporated psychodynamic themes such as attachment and persecution. Here, I have moved beyond phenomenology, adopting a more Ricoueurian hermeneutics of suspicion; in other words I have analysed more critically and used a psychoanalytic lens, rather than just accepting what participants have said. This is particularly evident where the analysis focused on the participants' internal dynamics as opposed to their experience of social context. It is also evident where there appeared to be contradictions within their narratives. This reflection makes sense to me as during the latter part of my training, I was heavily influenced by and immersed in analytic models and the theories underpinning these, including Cognitive Analytic Therapy and Psychodynamic Therapy. In addition, I was also undergoing Psychoanalysis myself. Although it was not my conscious intention to bring this theory to bear upon my data, it is clear that my own assumptions have infiltrated certain sections, especially those that discuss loss. Eatough and Smith (2008) describe how this second level type of analysis, can facilitate a richer understanding of participants' internal experiences since it can account for participants' experiences as well as capturing these. Linked to this I would like to reflect upon how difficult it can be to bracket one's own assumptions and beliefs; especially since some of these may not be conscious or accessible. It emphasises some of the challenges inherent in attempting to put aside our own assumptions and to just allow the experience of another person to emerge, or to understand human beings in the totality of their life world. Another example of this can be seen in my recruitment poster (Appendix F) which contains an image of a vulnerable female in the corner. On reflection, this could have sent strong messages to the women whom I was recruiting that they are vulnerable, desperate or need help. In this way I am not bracketing my own ideas about what it means to be a female problem gambler and therefore what I expect them to tell me during their interviews. This powerful realisation fulfils part of my hermeneutic reflection and demonstrates one way that my own assumptions have influenced the research and findings. Furthermore, Smith et al., (2009) describe how IPA analysis can be 'coupled with' another level of analysis such as psychoanalysis (p. 106), but they propose that when this is done, the two readings should be presented separately to add clarity for the reader. Therefore if I were to repeat the study, I would include this layer as an additional and separate reading.

My next reflection is on the process of interviewing as an interaction between the researcher and participant. This emphasises the interview as a co-construction and my own influence

within this. I felt that the women were making sense of what they were telling me as they were recalling their experiences, and that I was influencing the way in which they reported these experiences. Despite my efforts to make the interview as informal as possible and build rapport, some still appeared nervous or inhibited and concerned to provide a 'correct' response. Most participants apologised at some point during their interview that they 'weren't being helpful' as though they somehow had some preconceived idea of what I needed them to tell me. This seems to highlight the significance of meanings being negotiated between researcher and participant within a particular social context (Finlay, 2002a), leading me to further question my part in this shared construction of meaning, experience, self and lifeworld. For example if I was a fellow problem gambler in treatment, how might this have impacted on what they told me? In order to rectify this, I consider my own role to have been crucial as a means to help the participants express themselves, be heard, understood and then to accurately reflect these through my interpretation and discussion.

This brings me to my most poignant reflection point which echoes Kvale (1996), that learning to become an interviewer takes place through interviewing. Practice is the main road to mastering the craft and I felt more practised by the last few interviews, which impacted on the quality of data I was able to collect. After transcribing all of my interviews together – in keeping with IPA – I faced a new dilemma. On hearing the interviews back, I realised that at times I did not encourage participants to go further with their responses through skilled questioning and probing, but instead at times I moved on to my next question. I put this down to lack of experience and my own anxiety about my interviews, being aware of my own time constraints and paucity of available participants to interview, should any go wrong. This was where I realise the importance of the role of my interpretation and also how 'messy' the research process becomes, rather like the process of therapy itself.

Another important reflection to make is on the impact of my dual role as a clinician and researcher at the [redacted]. Despite taking measures to put appropriate boundaries in place, for example emphasising to participants that an interview would not impact on treatment, I soon realised the extent to which this double role did impact on the process. Firstly, many participants asked me about my involvement as a clinician and I made the decision to disclose this information if asked. Secondly, I note that my work at the clinic is likely to have affected my questions and also my responses to what I was being told about treatment as at times I could identify with participant reflections. A source of reflection has been the extent that my ties and emotional investment at the clinic could influence my aspiration to gain meaningful

findings. An additional source of reflection has been my assumptions regarding the women's experience, which may have been influenced by my own clinical experience with women in treatment as well as conversations with other clinicians regarding this matter. All of which influenced the research questions that I posed and the interview schedule that I constructed.

I would also like to reflect on ethical issues the interview process as an interview enquiry is a moral enterprise (Kvale, 1996). The personal interaction affects the interviewee. Whilst I have highlighted guidelines that were adhered to including confidentiality, informed consent and consequences, I was also aware that I was speaking to vulnerable women who were describing deeply upsetting and private experiences and circumstances. At times, I struggled with the moral implications of this, aware of potential perceived power dynamics – myself being in the position of power. Having completed treatment and in many cases shifted to a better place, many of the women who I spoke found it visibly difficult to recall how things felt when they were still in the midst of their gambling problem. This highlights the significance of empathic treatment, sensitivity and care.

CHAPTER 3 – ANALYSIS

3.1 Overview

This chapter aims to present and discuss the themes which emerged during the process of analysis in an organised manner which demonstrates the overlap between them, conveying the convergences and divergences in the participants' experiences. The analysis of all eight interview transcripts resulted in the identification of three master themes, nine subthemes and four sub-subthemes. The raw data is presented and explained using verbatim quotations from the interviews, alongside the interpretive analysis, so as to demonstrate the shared and collective experiences, whilst also highlighting the idiosyncrasies of participants' experiences. Due to the extensive nature of the data, an account has been developed that firstly seeks to answer the research question and offer insight into the areas previously neglected in the literature, and secondly highlights some of the more interesting and unexpected aspects of the women's experience and journey through treatment. Rather than creating a sweeping account of everything that emerged, I have concentrated on presenting an in-depth, comprehensive account of some of the more prevalent and prominent themes that emerged. Throughout the chapter, whilst each participant's experiential account contributed to the development of the master themes, not all participants are represented within each subtheme. With the aim of ensuring that the subthemes are representative of the majority of the sample, a minimum of five participants have contributed to each subtheme. The participants are presented using pseudonyms in order to preserve confidentiality. Table 3.1 shows the meanings of symbols which can be found in quotes throughout. Table 3.2 below summarises the framework used to organise the study findings in master themes, subthemes and sub-subthemes.

Table 3.1: Meaning of symbols in quotes

Symbol	**Meaning**
[…]	**Omitted text**
……	**Pauses and silences**
(…)	**Non-verbal reactions**
[ ]	**Words added for readability**
Bold	**Words stressed by participant**
( )	**My verbal prompts**

Table 3.2 Master Themes, Subthemes and Sub-subthemes

Master Themes	Subthemes	Sub-subthemes
Master Theme 1: Running from the Pain of Loss	Early Loss and Separation	
	Loss of Identity as a Gambler	
	Staring into the Abyss	
Master Theme 2: The Conflict Of Seeking Help	Becoming a Patient	Independence vs Dependence
		Relinquished Responsibility vs Ownership of Problem
		Secrecy vs Honesty
		Avoidance vs Experiencing Feelings
	Barriers to Treatment	
	Helpful and Unhelpful Aspects of Treatment	
Master Theme 3: Negotiating Relationships	The Outsider	
	Boundaries and Power Dynamics	
	Stigma and Gendered Expectations	

3.2 Master Theme One: Running from the Pain of Loss

In this section, I explore the common thread that forms a tapestry capturing the essence of the participants' lived experience in which 'loss' is of paramount importance. There is some overlap between the constituent themes as the participants move back and forth, placing their narrative in context, however, each subtheme aims to capture a unique aspect of the master theme. In this way the individual subthemes are joined together by a common thread. In *'Loss and Separation'* I gain insight into participants' shared experience of early loss, reflecting on how this impacts on their experience of therapy. I observe how these damaged earlier relationships and separations shape the way individuals experience and relate to others, posing challenges for therapy, in particular the therapeutic alliance. I also explore more recent bereavements. In '*The Loss of Identity as a Gambler'* I discover more about how participants attempt to distance themselves from this pain of loss, using gambling as an escape route; therefore I begin to

consider what the prospect of giving up this identity may mean for participants. Finally in '*Staring into the Abyss'* I recognise the enormity of the challenge presented by the prospect of treatment, abstinence from gambling and the sense of emptiness, isolation and fear that accompanies this, considering how this is experienced by participants.

3.2.1 Early Loss and Separation

Six participants referenced early, recent or feared loss or separation in relation to their gambling treatment experience. The narratives portray that loss is in some way associated with their treatment journey, and I will attempt to describe what this means for them by unpacking different aspects of loss.

Four participants described or alluded to their own turbulent childhoods which appeared to be lacking in some way. They conveyed their experiences of being abused, neglected, let down or abandoned by their caregivers, resulting in traumatic and damaging experiences which appear to have shaped their fragmented sense of self. As an apparent consequence of these early losses, these participants resorted to gambling as a way to cope, highlighting their need to distance themselves from their painful reality. This idea of '*Loss and Separation*' recurred unprompted within participants' narratives, as they spoke about their treatment experience, placing their journey into context and indicating they may hold some hope that the treatment experience itself may have the answers they are looking for. Beth explains:

> *When I was a teenager I had nowhere to go and I didn't know where to go[…]I started gambling as a child because I was from a violent alcoholic family and I felt safer in an arcade (BETH,* 89 - 632)

I experienced Beth as being intensely troubled by fears of abandonment as she experiences being repeatedly let down by others, stemming from her early conditions growing up in a 'violent alcoholic family' home, which felt so terrifying and void of love, that an 'arcade' seemed a 'safer' alternative in which she discovered gambling. As Beth recalled that she had 'nowhere to go' but also how she 'didn't know where to go', I felt her helplessness and imagined her as a lost child, without direction or guidance; alone and abandoned. For Beth, the feelings of helplessness associated with her neglected childhood appears too much to bear, as she warned me off discussing her childhood experiences ten times during the interview (40, 89, 123, 137, 156, 427, 429, 538, 546, 642). However, each time she introduces the topic herself, unprompted, drawing my attention to her psychological entrapment and rumination about this

period, with a desperate need to distance herself from the pain associated with it, as she comments:

> *My parents….I won't go right into it, but they were incapable of teaching me skills in life so I don't know how to cope with anything and had to learn from professionals how not to lie and to learn from a mental health team, coping. I still have times where it's hard…it's hard when you're alone. (BETH, 546 - 550)*

Beth's anger towards those who have let her down is evident throughout her narrative. She views her parents as 'incapable' and this is how she has come to understand her own difficulty coping with or possessing basic life skills or qualities, such as honesty. She experiences her childhood as a life sentence, as life is 'still' hard and her family's disapproval and neglect continues to preoccupy her, as she explains:

> *I don't have any support from my family and they think differently of me, they think that urm I'm a waste of space, they think that, my sister* ***doesn't even meet me for coffee*** *because she thinks I'm a* ***gutter*** *person. (BETH, 594 - 599)*

Beth's frank and powerful acknowledgement conjures up images of her family looking down on her with disdain, casting her away as though she is damaged and dirty, viewing her as a 'gutter person' or a 'waste of space'. This experience appears to be repeated in other contexts with her prevailing sense of being all alone in the world, unable to rely on others for support or help, as she describes: 'all the things I've done, I've done them by myself' (603) 'I felt so unfairly treated' (352), 'I kept phoning them and pleading them' (502). I sense this worldview of herself and others maintains her belief of herself as being powerless, as she continues to search for solutions, hoping 'mental health teams' have the answers she is searching for. Yet anticipating abandonment and the inevitability of rejection on the part of the other means that for Beth, the only certainty when relating to others is that she will ultimately be left all alone, rendering her helpless.

Like Beth, Catherine came from a broken, dysfunctional family where her needs were not met. She described her turbulent childhood, a family with many secrets, and her forced separation from her mum when she went to live with her grandmother, who she views as 'more-or-less my mum' (23), from a young age. As we reflect on Catherine's experience of treatment, she appears to side track my question but acknowledges that since having children she gambles less, which takes her back to her own empty childhood, as she explains:

Interviewer: And erm, has treatment changed your experience with gambling? (INTERVIEWER, 216 – 217)

Catherine: Yes like I said, I used to be in [the arcade] every day before my children I was probably in there as soon as it opened until 8, 9-o-clock at night; I used to live with my nan when I was younger and that's where I'd spend the day (CATHERINE, 218 – 221)

For Catherine, who is the only mother among all the participants, it seems that her experience of having children is a painful reminder of her own troubled experience as a child. While her mother was absent, it seems her father's love was conditional and inconsistent, as she explains:

I first fell pregnant when I was 15, but miscarried early and I fell pregnant again at 17 and didn't see my dad again for a long while so he's only recently back in my life (CATHERINE, 368 – 370)

As Catherine reflects on her loss as a teenager when she 'miscarried', before falling 'pregnant' again, the loss of her father also seems prevalent, as she welcomed his return.

Jacqui, Catherine, Natalie, Alice and Beth described recent deaths of family members, three of whom directly linked these to their gambling behaviour. It is as though the pain of loss is too unbearable to process and so gambling provides a temporary escape from reality. For example, Jacqui placed much emphasis during her interview on the impact of bereavement in her life and attributed her problematic gambling to this loss; she views gambling as a temporary response to these losses, describing it as a '*phase*' (92) and an '*episode*' (89). She described how she had '*blown £70,000'* (113) of her parents' inheritance and it was after losing this money that she felt she needed to '*redeem herself'* (83) by seeking treatment. It is as though she could not accept the death of her parents and so gambled away her inheritance, perhaps with an unconscious desire to lose the money. Now she appears to be looking for forgiveness or acceptance through treatment, as though she feels guilty for her actions. She sees this 'bereavement' as being of paramount importance, attributing it to her gambling problem and suggesting this is what she would have liked to focus on in therapy rather than gambling, as she remarks:

Interviewer: *Is there anything that would make [therapy] more personal for you? (INTERVIEWER, 368 – 369)*

Jacqui: I don't know, in my instance just focusing more on bereavement because I know that's where [my problems] stemmed from (JACQUI, 370 – 371)

Jacqui came to understand her sister leaving as another bereavement, or perhaps even a punishment, as she explains:

> *She went to live with some guy, it didn't work out and she never came back to me[..] it's another bereavement (JACQUI, 128 - 131)*

She denotes how painful this was, describing powerful feelings of abandonment which she described somatically as well as psychologically, as she felt 'heartbroken' (128) and 'estranged' (129). She explains:

> *It was the first time I'd really been on my own, there was just no support.. she left and it really escalated […] it was horrendous, scary, terrifying, just felt so vulnerable. (JACQUI, 116 – 121)*

Jacqui feels unsupported and she perceives herself as being unable to cope or manage alone. Her narrative seems to be one of being judged or even persecuted by others, yet needing them in order to cope. Like Jacqui, Alice had experienced deaths prior to the onset of her gambling problem. She explains:

> *All my family started dying, they were all old, but they died within 7 years. (ALICE, 112)*

For Alice, the deaths of 'all' of her family seem to have left her feeling as though she has been abandoned. She too found solace in gambling. Unlike Jacqui and Alice, Natalie acknowledges the anger she felt when her mum died. Like them, she sees a link to her gambling behaviour following this bereavement. Natalie explains in the following quote:

> *I'm angry at the world, it's like* ***why did my mum die, why did my mum die?****…Maybe I should have had counselling when it happened at the time, everything spiralled from there (NATALIE, 399-400)*

Here Natalie communicates her anger towards 'the world' as she repeatedly questions 'why' her mum died. The pain resonates as she appears unable to process or accept this loss but instead continues to search for answers or reasons why, perhaps as a way to fill the gaping hole she is left with and to regain a sense of control or order as she acknowledges how things 'spiralled' since her mum's death. This short excerpt also highlights the importance of timing for treatment, as she acknowledges needing help 'at the time'. This is discussed in more detail in Section 3.3.2.

These references to early losses and bereavement imply that therapy should address the sense of loss and pain that participants experience following the separations from and deaths of close others. But also pertinent is whether participants are able to form healthy therapeutic relationships following these significant early losses and how this ought to be addressed in therapy. Another important issue raised is the significance of the timing of therapy.

3.2.2 The Loss of Identity as a Gambler

All participants described how gambling provided relief from their realities, that it was a way of coping and masking their pain while offering hope. This experience seemed to enable them to soldier on in an otherwise intolerable environment, providing an escape and even offering a new identity and sense of self. All eight participants describe how gambling did this in different ways and allude to the loss they would feel if they were not able to gamble. Alice acknowledges her gambling served as an escape from her untenable reality. She sums this up here:

> *I think I gambled originally because I wanted an escape from reality, I was miserable and you know there's a lot of pressure on me in different ways with my family and stuff looking after them and things like that. (ALICE, 280 – 283)*

I experience Alice as being easy-going and even somewhat child-like in her appearance and demeanour, with a tendency to regress as she speaks in a childish voice, using language such as 'silly' (342, 343, 447, 487), 'nasty' (277, 363)) and 'stuff'(107). She has short hair and is dressed in tomboyish clothes, with jeans, a t-shirt and trainers. From her narrative it seems she wants to avoid stress and enjoy a more care-free life, following her recent stint as a carer for a number of family members who became ill, as she recalls feeling 'tortured' (530) by some of their demands upon her. It seems that gambling provided a release from all the 'pressure' and 'misery' she experienced when she felt demanded of by others. Gambling served as a protective shelter for her as she acknowledges: *'I was in a bubble' (432).* For Alice, giving up gambling - her protective shelter - also represents putting on weight, which she reminded me about several times throughout our interview. She explains:

> *Since I stopped gambling, I started to put on weight, because I always had a galloping metabolism... …( )Yeah, now I'm* ***fat*** *(ALICE, 93 - 103)*

As she makes a joke about her weight 'now I'm fat', it appears her weight gain has negative connotations for her. Her repetition of the fact and awkward body language communicates her self-consciousness about her physical appearance. There is a sense of loss of her former slim self which she sees as a consequence of her abstinence from gambling. Yet the insulation created by her fat, may serve to protect her vulnerable self from the outside world in the way that gambling previously created a 'protective bubble' for her. Perhaps the holiday she has planned with her partner is another means to escape into a 'second childhood', she explains:

> *In December we are going to Lapland to see Father Christmas….it's a second childhood (ALICE, 205 - 206).*

Seven of the participants I spoke to described how they had been long-term gamblers (more than 10 years), which communicated their level of dependency. For them, letting go of gambling and losing this sense of identity could pose even more of a challenge since they must face withdrawal from what might be their only attachment. Amy and Beth explain:

> *To be honest I started the fruit machines a long time ago, you know, it built up and up and up and got worse and worse and worse over the years, a lot of years […]I'm 41 now, I gambled since I was 18. (AMY, 332 – 340)*

> *I have been a long term gambler since I was a child I didn't know how to live my life without gambling. (BETH, 40 - 41)*

For these women, gambling has become entrenched; a part of who they are, and, as Beth highlights, life without gambling is a scary prospect, since she does not know 'how to live' without it. This communicates her anxiety about how she might function without gambling, as though her emotional development has been put on hold since the trauma of her childhood experiences, at which point she ceased to learn how to take responsibility for her actions, unable to process what happened, but instead retreating and becoming immersed in the highs and lows which accompany gambling. Gambling took the place of commitments and responsibilities such as work, study or family commitments, as she regretfully reflects:

> *I look back and I think I should be in a stable relationship or married and have children, should be because I wanted it in life, but my gambling came before and that's something I can't get back (BETH, 634 – 666)*

For Jacqui, Catherine and Amy, gambling provided a sense of purpose or belonging. Jacqui described her '*gambling career*' (15), stating '*it was like a full time job*' (204). In this way it gave her a sense of being needed and focus she otherwise lacked, she explains:

> *it just felt like I was part of a group when I went into the betting shops or the casino[…] I'm very shy but then I was never shy gambling you see I, that's the only, I was never shy you know, I could walk into a betting shop on my own, no problem, walk into a casino on my own, no problem. (JACQUI, 22 – 35)*

For Jacqui, letting go of gambling also signifies the loss of being 'part of a group'. She felt accepted as a gambler; protected and validated. This is in contrast to my experience of Jacqui who describes feeling judged and persecuted by others. It is as though the betting shop or casino provided a temporary respite from Jacqui's lonely, rejected self, replacing her withdrawn, 'shy' persona with a new sense of 'confidence'. This sense of feeling safe and protected through finding affinity with a group is echoed by Catherine. She elaborates:

> *I found that when I was gambling I could switch away from all that I was in a different place, urm the people that surrounded me felt like my family in there, we became quite close although we probably didn't really know anything about each other, you felt kind of in your own little family and you didn't feel like you had any worries or anything. (CATHERINE, 62-66)*

It is as though Catherine has been searching for a family. Like Beth, there is a sense that she has been unable to process what happened during her childhood, but instead became caught up in a gambling cycle, as she too was a child gambler. It seems gambling allowed her to feel 'surrounded' by 'my family', also affording her the 'closeness' with others that she appears to crave, providing a temporary respite from her existential isolation. It is interesting to note that she views her new adopted 'family' in such a positive light despite her own negative experiences of family life. Yet perhaps there were parallels between this new family and her biological family, such as secrecy, dysfunctionality, distance or unpredictability as she recognises 'we probably didn't really know anything about each other'. For Catherine, to give up gambling, would mean letting go of her illusion of a new family and all the safety and protection this brings and returning instead to her own terrifying, chaotic reality, in which she is currently in hiding from her emotionally abusive husband. Amy also seemed to find direction and purpose through gambling in an otherwise less meaningful life where she appears to take a back seat. She explains:

> *My husband worked in a restaurant so I had a lot of time to play on the machines when I used to stand around waiting for him, before we were married. And I used to watch people play, friends, watch friends, blokes play and they taught me how to play and then I thought, oh I know how to play now, that's what got me into it. (AMY,527–531)*

It seems for Amy, gambling was something she could enjoy for herself, rather than 'standing around waiting' for her husband or 'watching' others, and in this way fading into the

background. When she gambles for example she has the attention of 'blokes' who teach her how to play. She went on to describe how gambling made her feel that she could be a 'winner in life' (546), perhaps counteracting inner beliefs or feelings of not being important or having a purpose and instead offering hope and empowerment.

In summary, this section seeks to illustrate some of the factors maintaining the participants' gambling behaviour and therefore to enhance understanding of what it means to have treatment, to risk removing the identity of being a gambler and the new loss that this would represent. In order to stop gambling, women must battle with the pain of withdrawal, the separation from and loss of that attachment, combined with the consequences of the gambling addiction and all its related problems. Next we will consider what remains when gambling is removed.

3.2.3 Staring into the Abyss

A profound sense of emptiness was evident among participants in relation to their earlier losses and their attempts to stop gambling, which is often the goal of therapy programmes. They communicated feelings of ambivalence and fear at the prospect of change and the empty space that would be created without gambling; this would also mean facing the reality of the feelings of despondency, isolation and anxiety they had been running from. For some participants this ambivalence was portrayed via their apparent fear of ending therapy or sense that they needed more. Others described how they had attempted to fill the void through activities. In this section, I illustrate how frightening this reality seems for participants. I start with an example from Beth as she vividly portrays the void here:

> *When you stop gambling my life was completely empty because my gambling filled my life, all day, all night, a few hours sleep and then back again all day, all night, a few hours sleep and then back again all day and all night, stop that and then it was completely empty and not physically doing anything and then mentally you're urm, not, urm, well some people do initially when you first stop gambling your head's still rolling, but all that sort of calms I found that very empty and didn't know what to fill it with (BETH, 32-39)*

As Beth described the repetitive cycle of gambling, it felt relentless; she seemed to embody the frantic experience with her head 'rolling' like a die, but when this stops or 'calms' she is left feeling physically and emotionally empty. She seems terrified of the vast emptiness and the void that lies ahead of her, which is almost too big for her to contemplate. For Beth, the prospect of looking back at her childhood, or ahead at an empty future, is unbearable. Once

the therapy ends along with the structure it provides, the empty space will exist again and this fear is articulated as she explains:

> *I've asked the manager for extra sessions to help me structure my week a bit better[…].I might continue to come on a Tuesday or go to a museum or something because I've quite enjoyed the journey and I might keep that in place (BETH, 41 – 610)*

Beth, like other participants, is not ready to end therapy; fearing the skills she has learned may not be sustainable for her in the long term. She looks to address her feelings of emptiness, hoping other people may have the answer as she asks the 'manager' for more sessions to help 'structure' her week. Her plan to continue travelling to London and to visit 'museums' emphasises the fear of the empty space that will be left when therapy ends. Like Beth, Catherine has concerns about ending therapy sessions, and articulates what this is like:

> *I find in counselling you sort of open your heart a lot and some things do get pushed to the back […] and then when you finish you think I wish I'd asked that but you can't because it's finished but if you could go back afterwards and say oh I found it really helpful today but I did want to ask about this, could you just explain it (CATHERINE, 177 – 184)*

She acknowledges 'you sort of open your heart a lot' revealing her need to connect with others, but it appears to leave her vulnerable, empty, and needing more as she wishes she could 'go back afterwards'. Emma also feels unsettled about the prospect of ending, which is illustrated by the following quote:

> *It would be great if there was the option to have ongoing treatment if you feel you needed it or even follow-ups; so I don't know you finish your treatment and then just say you meet once a month down the line and see how you're getting on and then maybe 3 months down the line and then maybe a year down the line just to make sure everything is okay. (EMMA, 274 – 276)*

Here Emma comments on her preference for 'ongoing' support, portraying her anxiety about the space that will be left once therapy has ended, with a desire to continue intermittent meetings just to 'make sure' everything is okay. For Amy, the prospect of the end of therapy is too difficult to even contemplate. During our interview, she seems to find it difficult to think at times and is mainly flat in tone; as I ask her about ending treatment, she avoids answering the question, but instead becomes animated and excited as she starts to describe her experience of watching a friend gambling. She explains:

Interviewer: What's it like being at the end of treatment? Is there anything that comes to mind about it? What will it be like ending? (Interviewer, 33 - 34)

Amy: Well, like the other day I was sat in the British Legion where we go for a drink and my friend, he's an 80 year old friend and he went on the fruit machine and I'm looking at it, looking to see how much he's won and it was flashing up and down, flashing, flashing (eyes light up) and all the lights were flashing and I was wondering how much he's won (AMY, 35-40)

As she comments on the 'flashing' lights I notice Amy's eyes lighting up and she appears mesmerized by the memory and for the first time during our meeting I detect a spark of life, as her despondency subsides. It is as though the memory of watching her older male friend gamble and the flashing lights temporarily fill the void that may be left once her treatment ends, replacing fear or emptiness with excitement and hope, transporting her to a different space. Diane imagines her life without gambling, describing her sense of loss that she can no longer gamble 'like most people' as she explains:

'Which is a shame I think because there is probably a way of, like most people of still being fun and not ever leading to that, just for most people you know having a drink, it's nice as long as it's not imbalanced. (331 – 334)

Some participants who appeared to be 'solution focused' communicate their efforts to overcome feelings of emptiness through activities and exploring new interests. It is as though they are looking for something that will sustain them outside of therapy. This is encouraged in the CBT programme. It seems that Alice views her partner as a parental figure who nurtures her and has helped her fill the void, arranging activities and holidays for them to enjoy together. She explains:

We had some actual skiing lessons, then she bought me a load of paints and canvases, although I don't paint very well but it, for a few weeks we were doing that and we did other things, we were going to the pictures and well we've not really done anything together for a long time. (ALICE, 230 – 237)

Yet despite this attempt to fill the void, she fears looking back or connecting with difficult emotions, as if she is afraid to look at the emptiness, she explains:

I don't dwell on it…I don't think it's worth dwelling on. I think what happened, happened and I'll just stay clean in future […]*I just want to stay positive, if I stay positive and upbeat I wouldn't go back, I don't think (ALICE, 331 - 489)*

Her attempts to stay 'positive' and 'upbeat' highlights her fear of what the emptiness is like; it is as though if there were nothing there, the 'misery' might creep back in again. Similarly,

Emma, who is coming to the end of her therapy describes how she has taken on new hobbies, appearing to relish the 'doing' aspect of therapy in a supportive working alliance:

> *I've learned to fill the void and really be proactive and deal with the things that were discussed in therapy like, I've got too many hobbies now. (EMMA, 306 - 308)*

I was struck by her explanation of how she 'learned to fill the void' and her acknowledgement that she now has 'too many hobbies'. It seems important to her to be a 'good client' and a 'good participant' and in this way to please others. Yet despite putting these measures in place, she is feeling unstable about the prospect of ending and repeats this concern of the sustainability of treatment:

> *I feel strange not being able to come back again and I said I suppose it's like when you're riding a bike and you've got the stabilisers on and then you have to take the stabilisers off and after my treatment I did worry that I've not got the …. You know (EMMA, 143 - 149)*

In this section I have attempted to capture the emptiness and fear that women's experience at the prospect of giving up gambling. Letting go of gambling and ending therapy means change, uncertainty and fear. This highlights the delicate balance that must be achieved in the therapy space, where fear of failure, but also a paradoxical fear of success, may be a very real prospect.

3.3 Master Theme Two: The Conflict of Seeking Help

In *'The Conflict of Seeking Help'*, I gain insight into some of the key internal and external conflicts that participants have experienced relating to their journey of seeking and receiving treatment and consider how this weaves in to their overall experience. In *'Becoming a Patient'* I consider some of the internal struggles that women describe in relation to playing the role of a patient. In '*Barriers to Treatment'* I explore some of the accessibility issues described by participants and consider their significance for successful engagement in therapy. In '*Helpful and Unhelpful Aspects of Treatment'* I consider the varying perspectives presented by women on the positive and negative aspects of treatment and the accompanying conflicts with regards to seeking help.

3.3.1 Becoming a Patient

Many conflicts were identified among all participants' experiences in relation to becoming a patient, which have been separated into sub-subthemes for the sake of clarity. These conflicts, which were pervasive throughout the interviews, appear in the following order: '*Independence vs Dependence*'; '*Relinquished Responsibility vs Ownership of Problem'*; '*Secrecy vs Honesty* ' and '*Avoidance vs Experiencing Feelings'*.

3.3.1.1 Independence vs Dependence

Participants portrayed a world where relating to others or their therapist is a daunting prospect, posing a risk to self, following the losses they have already experienced. For some, a position of 'independence' keeps them safe and perhaps desirable, as they must not risk appearing needy or depending on others for fear of being let down as they have been in the past. For others a position of 'dependence' is taken as they believe they need help from others in order to cope in the world, finding it difficult to manage their own emotions. In this way, they appear to lack confidence in their own decisions. These positions may not be fixed, but vary depending on context.

Diane, who gambled online, communicates the importance of her independence in several ways. Throughout the interview I experience her as wearing a mask and in this way it is difficult to gain a sense of her inner world, which she keeps hidden, keeping me at a distance, as if to protect herself. She warns me away:

> *I'm kind of detached from it all now (DIANE, 54)*

Here, by letting me know she is 'detached' from the experience, I sense Diane does not wish to revisit it psychologically. She meets me during her work lunch break, is dressed immaculately with her hair neatly tied back. She stays away from the topic of her own painful emotional experiences or difficulties, instead mainly focusing on what it was like to be trapped in the gambling cycle and intellectualising many aspects of her experience, for example she explains:

> *When I was seeking treatment and reading about this more and more and I was feeling down I did read loads of books for people who had been through this before and its limited, but you do get the odd biography and its quite interesting and I suspect that women are more likely to come to the conclusion that there is an issue*

earlier, but not necessarily do anything because you're more likely to blame yourself, like you know but you might also think you can control it (DIANE 230 – 238,)

Rather than sitting with or exploring her own feelings she tries to relate to others and find a shared experience by reading 'the odd biography' to understand what it is like for other women gamblers, in this way taking the focus away from herself. Although it is hard for her to open up, I believe she is telling me about her own tendency to 'blame herself' as she felt she should be able to 'control' her gambling, implying she has high expectations of herself. Her difficulty in asking for help and caution about getting close to others is evident as she compares herself to others, acknowledging the challenges she faced in becoming a patient. She explains:

I'm less open, I internalise a lot, I wouldn't say it was really difficult, it's just a personality style you know I keep stuff in a lot and some people are much more, urm, not open but just talk about themselves more and I just don't really do that in daily life so that was a challenge I think. (DIANE, 71– 75)

For Diane who is 'less open' and tends to 'internalise', opening up to a therapist and allowing herself to feel dependent on another does not feel natural. This is further emphasised by her preference not to seek help, as she explains:

I don't go to the doctor unless I'm ill, unless it's really bad, because it's quite a rigmarole to go, so there is a barrier, the other is sort of a responsibility that I should sort it out myself. (DIANE, 139 – 145)

As she reflects on what held her back from seeking help sooner, she acknowledges only asking for help when things are 'really bad' and the 'sense of responsibility' she feels to solve problems herself, without the help of others, perhaps this is what she means by the 'rigmarole'. While her intention may be to communicate to others that she is self-sufficient and can cope, I experience her as being fragile and find myself tiptoeing around some of my questions. Perhaps her experience of me as a woman of a similar age, in a perceived position of power as the 'researcher' or 'trainee Counselling Psychologist', seeking to gain answers from her, contributes towards the dynamic between us and it is difficult for Diane to allow herself to be vulnerable with me. This dynamic also seems likely to have played out with her therapist, limiting the potential of the intervention.

However, on the opposite pole, four participants communicated a self that is more dependent, lacking belief in themselves as powerful women and therefore relating to others from a more childlike position. While it is difficult for Diane to ask for help, Catherine appears to have an insatiable appetite for therapy; she lists groups she has

attended including ‘women in abuse’, women’s aide’, ‘alcohol abuse’ and ‘domestic violence’ (279 – 280). Catherine repeats her desire to have more contact with her therapist, as though she felt unable to manage by herself without this additional input. She explains:

> *..in session although you kind of feel vulnerable you feel kind of safe and erm you feel you can let everything out but suddenly it’s ended and you’re leaving and you’re going back into the real world again and you feel vulnerable again[…]I think if I knew to myself the session’s going to end in 10 minutes but I can message her later or on the train on the way back I didn’t quite understand what you meant by this, I think that would have eased me a bit. (CATHERINE 197 – 205)*

Unlike Diana who was guarded and boundaried, I experienced Catherine as open and more expressive. She describes her feeling of containment in the session as she feels ‘safe’, unlike in the ‘real world’ which feels a frightening and threatening place for her, in which she is ‘vulnerable’. Whilst she appears to crave a connection with others, wanting to ‘let everything out’, she is then left with the prospect of emptiness again, needing reassurance that her therapist will still be available for her later, in order to ‘ease’ her anxiety. The prospect that she may not ‘quite understand’ something seems overwhelming for her to sit with and this concern is repeated several times throughout the interview. It is as though she is unclear about what she might want help with but there is a neediness that is communicated. While each position of independence and dependence serves as a protective function for participants, they also have consequences for therapy as these women’s inner voices and needs remain suppressed causing an inner conflict and push-pull effect, which may be difficult for less experienced therapists to manage without adequate training. This demonstrates the delicate balance that needs to be created in the therapy space, to enable women to experiment with the therapeutic relationship, learning to articulate their needs, but also a space where boundaries are fixed to maintain a safe space.

3.3.1.2 Relinquished Responsibility vs Ownership of Problem

Exploring the way participants conceptualised their gambling problem illuminated further conflict for some participants; these perceptions of ‘the problem’ have aversive and positive effects on their treatment experience. One way this was communicated was via their descriptions of motivation for seeking help. In order to engage in therapy, clients must feel ready for change, but this is not portrayed.

Seven participants described significant others as being the main motivating factor for their seeking help. Catherine, Natalie, Alice, Amy, Jacqui, Emma and Diane all described how their family members or partners were pivotal in their decision to access help. For Diane and Alice, their partners were encouraging or demanding for them to seek help. Alice explains:

> *It was my partner who I live with, urm she'd had enough of me, she found out about this place[…].She carried on to me and said you've got to do something yeah so I phoned them (ALICE, 21 -50)*

Here I have a sense of Alice taking a more passive role, being persuaded to seek help over a period of time as she described how her partner 'carried on' at her. There is a sense of her needing strong encouragement as her partner said 'you've got to'. She understands, 'she'd had enough of me', as if she is aware of her own process and the impact that this might have on her relationship. Diane felt her partner's encouragement using a similar tone: 'he made me'. Yet both participants acknowledge that they needed this encouragement to ask for help, as though there is some internal barrier to their asking for help alone. She explains:

> *He organised the treatment, he made me seek or encouraged that, I kind of needed him to help. (DIANE, 9-10)*

Catherine's fear of losing her children drove her to seek help, yet her ambivalence is evident. She explains:

> *If I can't fight this they [the children] would be taken so that's a big incentive […] I don't think if I didn't have kids I'd stop. I'd still be gambling (CATHERINE, 60 - 71)*

For Amy, who described arguments with her partner as a motivating factor for stopping gambling, another professional encouraged her to seek help during a recent stay in hospital. As she recalls the event I am reminded of a sense of distance, passivity and lack of ownership of her own decisions and choices

> *I can't remember why, I started talking about it in therapy at hospital and I suppose they said do you want any help and I thought well it can't be wrong to get help and, oh, that was it. (AMY, 102 - 104)*

Four participants portrayed their desperation before coming forward for help. Natalie and Beth described suicide attempts and saw their lives as depending on getting treatment. Emma and Jacqui used the phrase 'hitting rock bottom' to position themselves prior to treatment. Emma explains:

> *I was at such a low point I wanted anyone or anything to help me….I was rock bottom. (EMMA, 35 – 39)*

Prior to seeking help, Emma described 'denial' of the problem, which other participants also relate to. Emma explains:

> *I didn't think I had a big problem, but clearly I did, that was me in denial and me concentrating on other people's issues, I felt like I was I don't know just taking the limelight off me and was trying to help others. (EMMA, 202 – 205)*

Emma felt she was able to focus on others', rather than her own needs, and in this way continued to avoid reality. This provides a glimpse into Emma's inner world, where she hides from the 'limelight' and takes refuge from feeling needed or being able to help or please others. This 'denial of the problem' is compounded by an inner desire for many participants to continue gambling, which is illustrated by Amy as she explains:

> *I still dream about it, urm, about the gambling. .. I don't think I'll ever get over it. (AMY, 179 - 180)*

Amy's admission that she still has fantasies about gambling combined with her resignation to the idea that gambling will always remain a part of her has enormous implications for treatment, as it highlights the conflict between the reality of treatment and what is happening in Amy's inner world. This sense of ambivalence is a common theme among all participants, many of whom communicated that gambling is a part of who they are, alluding to a permanence about it. Natalie and Alice explain:

> *To say you're totally cured is wrong, you'll always be a gambler. (NATALIE, 284 - 185)*

> *I think it's like they say about alcoholics, they may stop drinking but they're always going to be an alcoholic and I think that's the same about gambling. (ALICE, 261-262)*

Natalie sees her gambling problem as an illness with a 'cure' removing her capacity to fully recover, as she suggests you can never be 'totally cured'. While Alice compares gambling to alcoholism, suggesting it becomes a part of the person whether or not they are actively engaged in the activity. Many of the participants' accounts are indeed littered with the language of addiction, such as 'experiencing cravings and urges', being 'out of control' (DIANE, 189), 'you just get drawn in' (DIANE, 109), or feeling a 'compulsion to do it' (ALICE, 154) or 'quirk in the brain that causes me to do it' (ALICE, 129), depicting how they become addicted, or taken over in some way and therefore may not feel able or ready to stop. For example, Catherine,

who perceives herself as addicted, is not ready to give up gambling but would prefer to learn how to hold on to her winnings rather than to stop gambling. With regards to her treatment experience she explains:

> *I think I would have liked to be able to control how to cope with winning a big amount of money and not being able to go back in so we never really looked at that side of it. (CATHERINE, 129- 131)*

Catherine is still holding onto the hope that she may be able to 'control' winning a large amount of money, and in this way, she seems ambivalent about stopping.

In these narratives, I hear a clear message that therapy is a last resort and participants are forced to seek help as a result of the destruction that their gambling problem has caused, either through desperation, or to please others. For some, relationships - or perhaps fear of losing significant others - are a main motivating factor to seek help, which demonstrates how central relationships are for these women, leading me to reflect on the emptiness discussed in the previous section. In addition, many women perceive gambling as an addiction which is part of them, and in this way there is a sense of relinquished responsibility around the gambling problem itself and a strong undertone of ambivalence, posing a challenge for the therapy from the outset.

3.3.1.3 Secrecy vs Honesty

Another conflict identified among all participants was that of overcoming secrecy and deceit which has become a necessary part of their existence as gamblers. The participants' narratives portray that, for all concerned, secrecy in gambling serves as a means of taking psychological control, even when they are 'out of control'. This enables them to cut off from their real feelings and also to protect their means to escape from their real-world experience. In order to engage in therapy, honesty and openness is a key requirement, yet opening up, trusting others and letting them in is frightening and involves risking the admission of failure as well as trusting that they will not slip into old patterns, or become lost in the needs of others. Therefore the position of secrecy is difficult to give up.

Natalie articulates the struggle she faced at different stages of treatment. Firstly when filling out her assessment forms which required information from her and later, in opening up to her therapist. She explains:

I filled in a self-assessment form which actually was probably one of the most difficult things cos some of the things it was asking, and then you had to tell the truth about it…all of it started coming out and that was quite upsetting because it was almost like even though you weren't saying it out loud it was when it was asking the questions you were thinking I have done something bad like that, you know I have done that. (NATALIE, 5-14)

She talked about having suicidal thoughts and things like that, you know It's quite upsetting but once you get over it initially it's good to actually talk about it. So they're the hard parts but they are probably the best parts. (NATALIE, 78- 81)

Natalie seems to experience relief as she has been able to open up and share her inner world, which she experienced as 'one of the most difficult things' and there is a sense of movement as she becomes unstuck as 'all of it started coming out'. She is able to face up to what she has done and begin to accept it as she acknowledges 'I have done that'. She underreports how terrifying this disclosure was for her, describing it as 'quite upsetting', yet she is able to communicate the conflict resolution she experiences as a result of opening up to her therapist as she says: 'They're the hard parts but they are probably the best parts'.

Yet she also acknowledges later on how secrecy remains a part of her life:

Even though they know about the gambling I have lied to them about the gambling as I went to a casino on Sunday and I spent £100, but I still lied to my boyfriend and said I didn't spend a penny, I just went to the bar and drank so I still lie about stuff (NATALIE, 255 – 259)

Natalie's ambivalence about stopping gambling is illustrated by this comment as she recalls a recent lapse and admits she has lied to her friends and boyfriend. Yet she has disclosed this information to me during our interview, which seems to highlight the controlled and selective nature of the secrecy, perhaps helping her to maintain a sense of control over the situation.

Introducing a different aspect of the secrecy, three participants (Catherine, Beth and Amy) recalled attending Alcohol Anonymous or Drug Anonymous groups in order to access support for their gambling problems, in this way testing out other services, curious to see what is out there and searching for a group that they can belong to or identify with, perhaps as a replacement for gambling. Beth and Catherine comment on these experiences:

I ended up in NA rooms and got some therapy from them (laughs), even though I couldn't stop, I was listening to other addicts, not gamblers but addicts tell how they coped. (BETH, 105 - 107)

I've actually started an AA meeting, not because I drink but because they do a 12 step programme….I've made some friends which does make it easier, although

they think I'm an alcoholic which I have had problems with in the past. They don't know I have other issues. (CATHERINE, 268 – 278)

There is a tone of desperation to Beth's and Catherine's experience as they have been dishonest in order to access support, however, there is an element of planning and control, as even while they attempt to access support, they are both wearing their protective mask, and in this way able to keep themselves distanced or removed from the 'other addicts', whilst paradoxically getting close, 'making friends' and 'listening' to and learning from their experiences.

3.3.1.4 Avoidance vs Experiencing Feelings

One of the biggest conflicts women must face as they embark upon therapy is that of experiencing and connecting with difficult feelings that they have been avoiding, including shame, guilt, fear, regret and anger. All participants I spoke to showed signs of avoidance of facing these difficult feelings. The gambling is in itself a mechanism to control these feelings, instead producing feelings of excitement, hope and distraction. The first feeling participants must tolerate is the uncertainty that accompanies starting treatment and the prospect of change. Natalie was among those participants who communicated what this felt like:

I really didn't have any idea what it was all about at the different stages and I kind of thought that….I kind of had the opinion that it wouldn't work and how can it work and I was also a little bit scared that it would change the way you think without me really, you know it would actually change my opinions on things though it sounds stupid ( ) (laughs) you know it was behavioural therapy I was thinking I don't want it to actually change my (laughs) brain but I'd like it to stop me gambling but apart from that I don't want anything like my personality to change. (NATALIE, 16 – 24).

Natalie articulates the uncertainty, doubt, mistrust, scepticism and fear she felt about therapy prior to attending, as she describes her concerns that 'it wouldn't work', 'how can it work?' accompanied by her fear of losing control at the prospect of placing her inner world in the hands of a stranger and relinquishing some control, in case this might 'change her opinions', 'brain' or even 'personality'. For Natalie, who admits she does not like feeling out of control, it was an enormous step to put her faith in professionals, with uncertainty fuelling her anxiety. As she told me of her concerns she appeared embarrassed, frequently laughing, letting me know 'it sounds stupid' as she fiddled with her hair and averted her eyes. It seemed difficult for her to communicate her fear, yet she was able to work through this and her relief was evident.

Diane uses time as a means of gaining temporal distance from her pain and loss, viewing time as a healer rather than attempting to actively connect with her avoided feelings. She explains:

> *It feels a bit like a shadow, exposed still, I think it will probably take a decade to look at it, to get some more distance, so although because time has passed, still not that far away, like it's far enough not to really be in the depths of, you know like those moments were very acute so it's far from that, and its far to, like you feel bad about, just, just feel awful for ages and there's nothing you can do about it. (DIANE, 344 – 355)*

She feels 'exposed', revealing the depths of her shame and embarrassment that she tries to keep locked away, yet from which she cannot hide since her dark, visible 'shadow', the part of her that she fails to acknowledge, follows her around. She seems to hold some hope that time will create distance, and finally perhaps she will be free from her shame or at least able to hide. Again there is a sense of helplessness and stuckness in her narrative as she acknowledges 'there's nothing you can do about it'. For other participants, an avoidance of difficult feelings was clearly communicated throughout their narratives, as six women expressed their grievances with the gambling industry in response to difficult questions which focused on them and their feelings, therefore taking the focus away from their own difficulties. Emma explains:

> *I hate myself for having this addiction, like I hate the, I hate that I've had this issue for 10 years, I hate the destruction that it's caused. I'm happy that I'm finally trying to combat it and I just feel I never want to; it also makes me angry, you know the way it's so freely promoted to other people, gambling it's just hard to. Gambling is just, I don't know, it's hard to, I feel disappointed that this has happened to me. (EMMA, 325 – 331)*

Emma communicates her disappointment and anger with herself as she repeats the 'hate' she feels towards herself as a consequence of gambling. Her use of language 'combat' illustrates the battle she faces and she begins to say 'I never want to', perhaps contemplating the idea of going back to gambling, yet something unbearable comes up for her and she switches to speak about her anger with the gambling industry instead; it is too much for her to face up to at this time. Like Emma, Beth frequently struggles to stay with her feelings during the interview, using different avoidance strategies including articulating several grievances with the gambling industry as well as other professionals. Speaking about the meaning of treatment for her, she explains:

> *To me it means putting my life back together, having a life that I should have had when you're, when I was younger and actually to have a jab about the gambling industry I am sickened that children are allowed to gamble (BETH, 428 – 431)*

For Beth, it is too painful to revisit her childhood and all of the loss and missed opportunity that encompasses. Rather than acknowledge and connect with her own emotional pain, she punches back at the gambling industry, choosing the word 'jab' and her use of language 'sickened' communicates how it induces illness in her physical body as she mourns the childhood she never had. Perhaps both participants are afraid of the potential consequences of their own anger. This tendency to avoid difficult feelings is likely to have been present during their therapeutic encounters too, showing how scary these feelings or emotional states seem.

The chosen narratives aim to capture the essence of the ways in which these women experience what it is like to 'become a patient', focusing on some of the main conflicts that organically emerged in the data. This includes the delicate balance between dependence and independence; readiness for treatment, the dilemma of facing the truth and putting aside their trail of secrecy to admit to their failings and finally, allowing themselves to connect with and experience some of the terrifying and destructive feelings they have been avoiding. This provides a glimpse of some of the conflicts participants must process, providing important information for service providers about the complex, inner worlds of these women, coloured by shame and self-hatred as they attempt to resolve these dilemmas alone. But there is a hidden vulnerability and helplessness which lies beneath the surface for all of these women and needs to be acknowledged.

3.3.2 Barriers to Treatment

Many participants referred to treatment as being 'inaccessible' or somehow difficult to reach as if too far away. They described their experiences of 'waiting' for treatment, the 'distance' of the treatment centre and the sense of searching for information or help, communicating this distance as being detrimental to the overall treatment experience. This sense of distance whether in space or time, seemed to encompass not only the physical proximity but also an emotional distance, as all participants communicate a desire for more flexibility, convenience and control over their treatment options. For some, the experience of waiting seemed anxiety provoking, conjuring up feelings of uncertainty and even helplessness. For others, the investment of time necessary for treatment seemed problematic, imposing and constraining. Other women viewed the distance in space and cost involved for travel as being an invisible but very real barrier to treatment. Many participants described their search for information which was not always readily available, with the disappointment that ensued. For three participants, being a woman was in itself a barrier to treatment. The thread that weaves throughout the dialogues communicates how some participants appear to feel disempowered

by the experience of waiting or the prospect of giving up their time for therapy or travelling too far, presenting some interesting challenges for treatment.

For Diane there was a strong theme of waiting and time, which ran throughout her entire narrative, from her unsettling experience of waiting for treatment, to a sense of losing time, boredom and an element of surprise or suddenness relating to her gambling, to her perception of time as a healer with regard to loss and pain. She explains:

> *I'd asked for treatment earlier but you can't know, because resources are limited you can't go straight away, so it was quite a few probably months had elapsed before actually getting it […]I think it came a long way after when I was really desperate. […] When you're just waiting it is one of those things where you just need it now, like that usually the point where you ask for help. (DIANE, 24 – 45)*
>
> *By the time I got to the sessions I was already urm I was in a period of abstinence. (DIANE, 77 – 78)*

For Diane, waiting seems to evoke anxiety, frustration and even desperation, with an element of uncertainty, 'you can't know', and a sense of being disempowered, 'you can't go straight away', and 'you just need it now', all of which is narrated in the second person as she distances herself from the experience. She recalls 'just waiting' which illustrates her preoccupation and sense of powerlessness. Despite letting me know that she understands 'resources are limited' she explains she was already abstinent 'by the time' she was offered help, communicating that she was let down and treatment came too late, highlighting the importance of timing for intervention, as she acknowledges 'if it had started earlier and gone on for longer that would have been very helpful' (376). This might also lead the reader to wonder how she achieved this abstinence. This sense of needing things immediately, or impulsivity, seems to resonate with her gambling experience as she enjoyed the 'instant feedback'. She explains:

> *'I would do blackjack and it's very, you get like instant feedback. […] very occasionally I'd get kind of bored and then I won a bit and then I started spending more time on it but it was still fine…you just get drawn in and the only way to make the game more interesting is to spend more but the thing is it can be over in seconds. (DIANE, 102 – 111)*

Unable to tolerate 'boredom' even while she gambles, for Diane time appears to be a valuable commodity, which ought to be filled with excitement as she needs to make the game 'more interesting' by upping the stakes. As she becomes more absorbed, time appears to speed up, until the inevitable disappointment when it ends and the game is 'over in seconds', which seems to encapsulate the difficulty she has with waiting for therapy, highlighting the importance of getting help before things become too critical. There is a recognition here that sitting with a

process may be difficult; akin to personal relationships and therapy. She communicates the conflict she experiences with regards to committing to therapy and giving up her time:

> *…. it's going to take your time and so on… I know it sounds silly but I'm going to have to fill out some forms and then make my way to X or give X hours a week […]it seems like quite a big effort which is probably worth it but when you've got X number of other things and kind of maybe I could just do more – cos I play a lot of sport – maybe I could just do more sport and that'll help because I'll be distracted so there are other types of options. (DIANE, 147 – 157)*

For Diane there is a sense that time is precious or limited as she describes 'it's going to take your time', as though she will run out of time, feeling a need to 'do more'. Filling out forms and travelling to the clinic also appears to be burdensome or imposed, as she reflects 'I'm going to have to'. A part of her seems aware this may not be a helpful way of viewing help-seeking as she says 'I know it sounds silly' and 'which is probably worth it', yet she is torn, as she imagines the other activities or 'sport' she could be doing instead. An alternative perspective that Diane is avoiding treatment, that she prefers to 'be distracted' so as not to engage with painful feelings. Like Diane, this sense of waiting for therapy and then making the commitment in time proved problematic for Emma who comments:

> *..there was a long waiting list and then unfortunately three months on the trot I lost everything each time so the only negative thing is that this isn't, there's only one clinic with a waiting list. (EMMA, 59 – 62)*

Both Emma and Diane articulated their understanding about practicalities within the service with regard to the waiting list, yet their disappointment is clear, as Emma acknowledges 'unfortunately three months on the trot I lost everything'. Like Diane, Emma also seems reluctant to waste time, which she expresses in this next passage:

> *I can see gamblers that I see have been going there for absolute donkey's years and it's more like that thing where they just, I just can't explain it. I don't want to be reliant on going, spending all my free time going there to stop myself from gambling, whereas here there's things you do in your free time to fill the void, you have to go out and do stuff, I have been going out and doing stuff which is much more enjoyable than sitting and pondering on what I've…the destructive behaviour I have done. (EMMA, 96 – 103)*

Emma articulates her fear of becoming like other gamblers, 'becoming reliant' or 'spending all her time' going to forums. This also communicates a very real fear of switching her dependence from gambling to therapy which is an unacceptable prospect for Emma, who like Diane, portrays the importance of her independence. She repeats that 'sitting and pondering' is not

for her, communicating her preference to keep busy 'going out and doing stuff', escaping anxiety rather than connecting with difficult feelings.

For Catherine and Alice, the journey from the clinic posed problems for accessing treatment, creating a sense of distance for them:

> *There was an after-group but unfortunately it was in the evenings and as it was in London I don't live that near and I wasn't able to attend….so that was the downside, I feel that I needed further help but I couldn't access it because of how far away it was and because it was late. I think something in the day would have been a lot easier. (CATHERINE, 24 - 29)*

For Catherine, distance and timing of sessions served as a barrier. It seems she would appreciate more flexibility and convenience, with 'day' sessions that might fit around her schedule. Childcare posed a further difficulty, which I will discuss in Section 3.4.3, as she explains:

> *I think being a single female has because of the childcare side of it and also I've got a very big fear of separation anxiety over my children so….unless there was something available at meetings I wouldn't want to leave them with anybody. (CATHERINE, 44 - 80)*

Catherine views herself as being unsupported as a 'single female', highlighting unavailability of help, yet in the same sentence she acknowledges her 'separation anxiety', which in itself acts as a barrier as Catherine becomes torn between getting help for herself and the anxiety she feels around leaving her children. An interesting juxtaposition emerges since her children have been both a motivating factor and an obstacle for Catherine to receive help, while she is unable to tolerate the isolation and overwhelming loneliness of her inner world.

For Alice, who works in a supermarket on minimum wage, the distance, cost and wait were also a barrier for her to access support, as she explains:

> *I didn't go (to GA) because they said whenever it was and they said wherever it was and the nearest place was (Kent) so …I didn't bother …It just got put on the backburner. (ALICE, 57 – 61)*

> *I live here, which is far away from there and it's expensive to travel to London if you drive in a car that costs money as well to park. (ALICE, 4 - 5)*

It is as though Alice feels somehow unwelcome by the prospect of travelling so far, but she was offered remote therapy which met her needs, as she explains: 'I think it did help me a lot more doing it remotely' (17).

Some of the women also described how they found out about the clinic, communicating that there was limited information available and other professionals were not aware of the service, even during as they describe their absolute desperation. Natalie explains:

> *To be honest, I didn't realise there was an NHS thing […] I don't think many people know about it[…] I went to the doctor a few times like I said about the suicide or gambling they never advised me about it[…]to be honest they just prescribed me antibiotics. (NATALIE, 306 - 318)*

Four women described how being a female had impacted on their ability to access treatment, with limited options available for women, which I will elaborate on in Section 3.4.3.

The narratives in this section demonstrate that the need for easier access of treatment for participants is important in terms of timing, location, cost and information. They support the notion that remote therapy, online counselling or telephone support lines may be a more feasible option for some women, in particular those with children.

3.3.3 Helpful and Unhelpful Aspects of Treatment

Capturing '*helpful and unhelpful aspects of treatment'* the participants' views of their treatment experience varied widely. For all participants there is a prevailing sense of needing a more bespoke or personalised experience, highlighting the manualised, 'one size fits all' nature of CBT. Participants all portrayed therapy as akin to school, where they enjoyed the opportunity to learn or be taught. Some described the structure, paperwork and learning new skills as helpful and containing, while others experienced this as rigid. Some took great pride in their homework and comfort in their cognitive self-understanding, while others found this to be overwhelming. Some participants relished 'doing therapy' preferring not to get too involved in their emotional being, while others wanted more space to explore their feelings. Many reported opening up and having someone to talk to as key.

Overall most participants reported therapy to be a positive experience, while one participant portrayed it as unhelpful. Whilst this study does not seek to investigate treatment efficacy, it was found that half the participants were still gambling at the time of their interview, half were abstinent, and of those, two attributed this to treatment while the other two were unable to pinpoint the reason for their abstinence or what was different now, as Amy explains:

> *I don't know if the treatment's good or bad to be honest. All I can say is I don't play any more. (AMY, 289 – 290)*

All participants described wanting a more bespoke or personalised treatment experience. Emma, Jacqui and Natalie describe how they have found some parts of the therapy helpful while other bits were not relevant, implying the therapy has failed to capture their own unique experience or needs:

> *Some things we went through probably I wouldn't use or wouldn't apply to me. (EMMA, 19)*

> *I just have to pick and choose the bits I feel are relevant and the bits I understand […]I don't think they concentrated on me specifically, there are a lot of things in this information they give you are so general and they're not specialised at all […] they could tailor it a bit and leave some bits out and put others in, just make it a bit personal (JACQUI, 289; 357)*

While Jacqui communicates her disappointment about the lack of focus on her as an individual, Natalie illustrates a specific part of therapy which she found unhelpful. She views this as 'a bit stupid' and her laugh at the end further belittles this part of the treatment programme, emphasising how unhelpful she found this particular technique and that perhaps she begrudged doing it, or felt embarrassed:

> *I also found some aspects worked really well but others didn't really. Like there was one lesson where it was about urm if you start to feel like you want to gamble you have to hold a segment of orange and what does it feel like in your hand and I just thought that was a bit stupid so I didn't do that because if I want to gamble I'm not going to stop and get a segment of orange you know (laughs). (NATALIE, 36 - 42)*

These descriptions highlight the prescriptive, manualised nature of therapy. While for Natalie this feels somewhat rigid, for Beth it is more containing and she especially appreciates the focus on the present and structured agenda. Beth explains:

> *I like the programme that it doesn't delve into urm past childhood and urm that distracts what, it's quite structured here so you are actually focused on what's happening, what happened and what you can do about it here and now and future.* (BETH, 27 – 32)

Natalie perceives therapy as a 'lesson', highlighting the 'taught' aspect of CBT, which was also communicated by other participants in different ways. Perhaps with this in mind some participants appear to construct their own role as students there to learn or be taught by the 'expert' therapist, which enables a sense of relinquished responsibility for some, as they look to be spoon-fed by the therapist, while for others it may be an opportunity to be a 'good student'.

Catherine also views the setting in a way that evokes a classroom setting, with the therapist or 'lady' centred in an expert role, as she explains:

> *There was a big board where the lady that I saw she would put things up on the board which I think made it a lot easier to understand and urm I think I found that really useful. (CATHERINE, 14 – 17)*

For Alice, it is important to be a 'good pupil', as she is keen to take away what she has learned and apply it correctly. She explains:

> *I hope to stay in control of myself and be positive and just build on what they taught me at the gambling clinic and if I did have any lapses or just silly thoughts that come through my mind about gambling or something, I just go back to my paperwork and read through it and just knock it out my head. (ALICE, 485 – 490)*

Her use of the word 'hope' seems to highlight her own uncertainty of the future and a fear of relapse as she describes wanting to stay 'in control of myself', as though she is afraid of making a mistake. She hopes to 'build on what they taught me', in this way positioning herself as a pupil who is keen to learn from her teachers. She refers to her 'paperwork' several times during the interview, taking great comfort in having this guide to keep her on track and deepen her cognitive understanding. She sees her problems as 'silly', dismissing her own needs, but also keeping things light, rather than allowing herself to engage with painful memories or thoughts. In this way she does not wish to engage with her emotional being but is able to remain distanced from her problems, which she hopes to 'knock (it) out my head', communicating the intolerable, unacceptable nature of these thoughts which she needs to eliminate.

Like Alice, Emma appears to view the treatment as an educational experience which has the potential of creating therapeutic change. She explains

> *This one-to-one treatment has been so beneficial to me in terms of techniques I've learned. Some things you might think that is common sense by my brain wasn't didn't probably want to think that way, it's just training my mind and I was really surprised by some of the techniques and how they worked …I found techniques like, urm, the mindfulness and the meditation not only has it helped me with the gambling thoughts and behaviours and triggers but also in other areas of my life, urm just some of the techniques of challenging my thoughts. (EMMA, 13 - 20)*

Emma's enthusiasm is evident as she has taken great comfort from her individual session which she found 'so beneficial', viewing the overall experience as a way of 'training' her 'mind' and 'brain' taking a positive view of behavioural conditioning. Her expectations were exceeded as she is 'surprised' at how much she benefitted from 'learning new techniques' which she found empowering, applying them to other areas of her life. In particular mindfulness appears

to have been an important aspect of therapy for Emma, enabling her to regain some control of her life. Unlike Emma, Jacqui found the programme to be overwhelming, in particular she struggled with the homework component:

> *It's hardgoing, it's very hardgoing, CBT, every week you have homework and sometimes I don't fully understand it, or it just seems like a psychology course (JACQUI, 40 – 42)*

She hopes to be listened to, valued and understood above all else and appears to find the 'hardgoing' cognitive tasks to be a distraction, becoming frustrated with the conceptualisations being brought into the room. She goes on to express her experience of the therapy as lacking in compassion, as she explains:

> *Then it could be more soft as well, I don't know just more caring. (317, JACQUI)*

While Jacqui felt uncared for in the therapy space, other participants saw therapy as a space where they could open up and felt encouraged by having someone to talk to, which they viewed positively. Alice explains:

> *They're trying to draw it out of you, aren't they really? They want you to bring it out and that's good and I did feel a lot better when things did come out. (ALICE, 77 – 79)*

This section has explored some of the key aspects of treatment which participants found helpful and unhelpful, highlighting their broad range of experiences with barriers and motivators. Overall, participants wanted a more personalised experience, most enjoyed learning new skills and many found it helpful to have someone to open up to. Participants seemed to be able to find aspects of the therapy which were helpful and which they learned from. The key criticisms were in line with more general criticisms of the CBT model, which will be explored in the Discussion Chapter.

3.4 Master Theme Three: Negotiating Relationships

This section encompasses the participants' experience of relating to themselves and others and considers the impact of this for therapy. In '*The Outsider'*, I focus specifically on their shared experience of feeling different or unique and the implications of this for the therapy experience. In '*Boundaries and Power Dynamics'* I consider the different ways in which participants negotiate relationships with others. In '*Stigma and Gendered Expectations'* I consider how the participants see themselves in a socio-cultural context and how this impacts

on their perceptions of therapy. The theme of relationships is not exclusive to this section since it is of paramount importance to the participants' overall experiences, but this section aims to delineate some of the finer nuances to help enable a deeper understanding of its significance.

3.4.1 The Outsider

Difference was a salient theme emerging in all eight of the individuals' narratives. Recurrently, participants' descriptions of themselves were compared to those of others and it was through this comparison process that areas of difference were illuminated. Participants described feeling as though they were unique, different, special or abnormal in some way, viewing themselves as '*The Outsider*' in a range of contexts. These descriptions communicated an expectation that they would fail to be understood, seen or heard by others, portraying an isolated existence in which they are left to cope alone, without validation.

All of the participants perceive their 'type' or 'stage' of gambling as different from that of other gamblers in treatment. Amy speaks about how she sees treatment as being set up for people who are still in the midst of gambling, yet she feels this is not applicable for her since she is abstinent. She explains:

> *I don't think it's hardcore treatment you know what I mean because I haven't played for two years I think my treatment is a little bit different because it's set up for people that are gambling now or stopped for a week or something. That's my opinion that it's set up for people that have been gambling recently. (AMY, 257 – 264)*

Here Amy communicates her disappointment that treatment is not fully 'set up' to accommodate her needs, interestingly she uses the word 'hardcore' as though it has not been intense enough for her. In this way she communicates that she has not been helped enough.

Emma also views her gambling behaviour as being different from that of other gamblers, which for her is the 'difficult part', as though it might feel somehow easier if she could relate more to other gamblers. There is a sense of concern that her gambling is worse or more destructive than that of others as she explains:

> *The difficult part for me was where I was, you get some gamblers who maybe do £20 per day and they still have money, my behaviour was really destructive, where I'd get paid and literally in one go I would lose everything ….When I've researched and had a look at forums to see if there's anyone else who has had this type of gambling behaviour I couldn't see it. (EMMA, 54 - 68)*

Perhaps she is concerned that she will be made to fit into a box marked 'gambler' rather than treated as a person and in this way something important may be missed for her in terms of treatment. This is highlighted by other participants in the previous section where they communicate the need for a more personalised treatment experience. Emma explains:

> *Even though we have all got the same thing, we're all compulsive gamblers we might have different gambling issues with different reasons and I think something that might work for the lady sitting next to me might not, you know it might not work for you know, yeah it might not work for me what works for the next person (EMMA, 115 – 120)*

The importance of recognising individual difference in herself and in others is clear throughout Emma's narrative. As she explains her comment 'even though we have all got the same thing' it is as though she is reminding me that she is more than just a 'diagnosis'. I sense that her anxiety to explain herself fully was a result of previous experiences of not feeling understood or noticed. She is tenuous and cautious in her descriptions, as she says 'I think' so as not to state it as a fact but remind us both she is describing something subjective and 'you know' as if to check that I am understanding and on the same page as she is. This sense of feeling misunderstood is echoed by Catherine, who explains:

> *I think the hardest thing to cope with is that it's not understood very well. Like I've had to do this with social services and one social worker said to my face that she doesn't see why I do it either. She doesn't see why I can't just say to myself I'm not just walking into an amusement arcade and I'm not going in to gamble, which hurt a lot because anyone who's had any form of addiction, even if it's cigarettes. If you actually know how the addiction is and what it actually feels like, you'd know the gambler does stuff with the same thing. (CATHERINE, 302 – 309)*

For Catherine, the 'hardest part' of being a problem gambler is not being understood, even by professionals, emphasising just how difficult this is for her. She uses the word 'hurt', exposing herself to me and revealing her sensitivity and potential to feel wronged by others, and the core of this pain seems linked to their lack of understanding about addiction and how it has felt for her. Perhaps this is indicative of some of her earlier experiences, growing up in a dysfunctional family, full of secrets, in which she was abandoned by her mother. It is as though no-one understood how difficult things have been for her or kept her in mind. She compares gambling to other addictions such as smoking as though she needs to justify or explain the reasons for her actions.

Four participants express that they have experienced this lack of understanding and sense of uniqueness or difference as a result of their gender in the context of gambling, discussed further in Section 3.4.4. Amy explains:

It's a weird thing for a girl to have. (AMY, 421)

For Amy, this difference is experienced as her feeling abnormal, as though she is 'weird'. This is echoed by other participants and illuminates their sense of shame and feeling judged by others with regard to their gambling behaviour. There is a suggestion here that it is accepted for men, however, hinting at inequality and stigma. Beneath these shaming beliefs and experiences lies a place of deep loneliness, rejection and isolation which is captured by Beth as she recalls her long search for help:

I was solitary for quite some time as the only woman. (BETH, 266)

Diane's desire to feel understood is communicated through her wish to have a therapist who has had a gambling problem. She explains:

If the therapist had been through stuff, that would actually be kind of helpful, and that is not the case most of the time, but it's not essential, it's just that it would be quite interesting to explore, or as someone who has been through something similar and can see it as well as someone who is more detached and trained in counselling as well, some kind of combo would tackle it from a number of sides. (DIANE, 264 – 270)

Diane hopes to speak to someone who has also 'been through stuff', as she searches for a shared experience and understanding and perhaps a sense of belonging or community. Once again she moves away from her feelings, articulating how it would be 'quite interesting to explore' as though it becomes an intellectual exercise with the focus more on the therapist's experience than her own; however, I sense that she would like someone who can connect more with her, as she feels a therapist without the gambling experience may be 'detached' and therefore removed in some way. By having a 'combo' to 'tackle it from all sides' it is as though she is trying to ensure everything is covered, as if in the past there has been a gap. Like Diane, Jacqui, Catherine and Natalie emphasise the importance of having a therapist with a shared experience. Jacqui explains:

I'm sure if you were going to go to a bereavement counsellor they would have experience of bereavement, so why should you be a gambling counsellor and not have experience of gambling…I feel like they're talking kind of like from a text book, I mean they're very good at what they do I'm not saying they're bad but they haven't got that little tiny thing that only a gambler would know….yeah I really don't think you can fully understand something until you've had it…they tend to look down on you and judge. (JACQUI, 470 – 486)

Like Diane, Jacqui desires a therapist with experience of gambling, as she questions 'why should you be a gambling counsellor and not have experience?' articulating that her therapist

was not able to make a real connection with her since it felt as if she was being spoken to from a 'text book', as though her therapist was intent on box ticking rather than getting to know Jacqui. It emerges that she has felt judged in therapy, as she feels her therapists 'look down on you'. I wonder if this resonates with her earlier experiences, as feeling judged and criticised appears to be a common theme throughout her narrative, suggesting she has had negative experiences of authority and inappropriate use of power and control.

In this section, the women present their experiences of feeling different, abnormal and even rejected by others both inside and outside the therapeutic context, which has important implications for therapy as it demonstrates their fundamental need to feel understood and therefore for the therapist to get to know them as individuals, to try to understand their unique stories and types of gambling and most importantly to accept them as they are, rather than attempting to categorise them with other 'gamblers', which invoke anxiety and frustration in the participants. Their narratives also indicate they may wish to foster a sense of belonging and community within and between themselves and others which could be created in a group therapy context.

3.4.2 Boundaries and Power Dynamics

Relationships with others is a central theme which resonates throughout all the participants' narratives. Participants' experiences of relationships appear to be both a motivation for gambling as well as for seeking help. These relationships appear to cause stress and pressure for participants, who describe how these difficult dynamics result in their attempted escape into gambling. For instance, Natalie described how feeling ignored by others would drive her to take control of her psychological pain and gamble, as she explains:

> *We kind of figured out it was a lot of…. it was because my boyfriend was out a lot, it was my boyfriend ignoring me a lot and was in the other room playing the Xbox, I would be bored and I would feel like, I would also be a bit like, if anyone annoyed me it would be a like sod off you I'm going to go and gamble, it was something…one of my own things that I could do, it would be like that no-one, I had my own world sort of thing (NATALIE, 51 – 59)*

I experienced Natalie's self as chronically unseen by others and yet unable to express her needs or articulate her vulnerability or pain. She portrays promiscuous tendencies throughout her interview, referencing several different boyfriends - unprompted a total of 7 times during our interview (330, 350, 363, 444, 508, 527). She recounts several examples like the above, which illustrate how this sense of being invisible would trigger a gambling episode or other risk-

taking behaviours, such as disorderly behaviour resulting in police cautions. She goes on to describe how, through gambling, she feels powerful, able to command the attention and visibility that she needs, empowering her and filling her own psychological void. She explains:

> *The night we split up I went mad, I said it was like sod you, I'm going to the casino now, look what you made me do, I went to the casino, took photos – you're not supposed to take photos but I took photos at the casino and sent them to him and I said look what you made me do, I managed to win £7 – 8,000 and took a photo of me with money all the £50 notes. (NATALIE, 332 – 338)*

While I interviewed her I was reminded of the 'fallen tree in the forest' and my thoughts turn to her fragmented sense of self; I sense that she needs to be seen (for example through 'photos') or heard by others (through winning money) in order to feel that she exists and gambling makes her feel noticed as she imagines everyone talking about her as she gambles on high-stakes; she explains:

> *You get caught up with it all, everyone's looking at you, everyone's like who's that girl spending £500 a spin that's what you get caught up in, I don't actually do it for the money, it's just the excitement of the spin. (Natalie, 374 – 377)*

Here Natalie fantasises about being at the centre of attention as she spends '£500 a spin' and imagines onlookers thinking 'who's that girl' as she demonstrates what she is capable of. It is as though gambling is a channel of communication or expression for Natalie, as she finds it difficult to ask for what it is that she needs or wants in a heathy way or to set firm boundaries around herself, and instead resorts to rebellious or defiant acts, frequently describing incidents when she goes 'mad'. Through gambling she is able to prove herself, as she acknowledges it's not for 'the money'. Like Natalie, Catherine experiences profound difficulties in her relationships with others and appears unable to get her needs met; for her, emotional abuse triggers anxiety and depression, yet through gambling she finds a way to hide her problems. She explains:

> *I didn't want to quit, in the past I used to get through every day, I used it to cope with my everyday life. I was living with an abusive partner and it was the easiest way of getting through it…..I found when I was gambling I could switch away from all that, I was in a different place (CATHERINE, 57 – 62)*

For Catherine, gambling holds the illusion of being an accessible solution, which is as simple and instant as flicking a 'switch' to alleviate her pain, in other words she is in control. It is interesting to note that Catherine's family enabled her gambling, seemingly giving her money rather than love and attention.

I would get money from my parents and gamble it and they didn't think anything of it then (CATHERINE,435–436)

In this way it seems she has a complicated relationship with money, in which perhaps she is trying to win more love through gambling. While analysing Catherine's recurrent descriptions of needing more from therapy, it becomes clear how difficult she finds negotiating relationships, seemingly unable to set boundaries between herself and others (including her therapist) and being left feeling vulnerable and empty at the end of her encounters, perhaps out of control and needy. Referring to her therapeutic encounters she explains:

It always seems to be for anything [therapy] it always seems to be an hour or less and I never feel it is enough. (CATHERINE, 167 - 169)

Like Catherine, Jacqui appears to have difficulties setting boundaries with others and this is highlighted by her descriptions of some of her encounters in therapy. That she experiences others as persecutory is a big obstacle for her to overcome if she is to be able to trust anyone and allow them to get close enough to her to explore her difficulties, or witness her full experience. She recounts her experience in the therapy space:

It's obvious they judge, they think you're an idiot, maybe I'm just being paranoid. (JACQUI, 490 - 491)

Jacqui finds it hard to '*identify with women'* (10) and in particular recalls one of the difficult encounters she had with another woman at Gamcare:

Well there was a woman at Gamcare when we were in the group, she had kids and I said to her one day, how can you gamble when you have kids? She practically bit my head off. (JACQUI, 410 – 411)

Here Jacqui provides an example of her difficulties negotiating relationships with others. She appears to lack awareness of her own mental state and the impact she has on others, as her narrative is often critical and negative, but just like the other participants, she communicates a deep need to feel loved and accepted. It is as though sharing her space with others is like being in a battleground which brings continual conflict and rejection and this presents challenges for therapy, since she may experience her therapist as being persecutory and therefore it may be difficult to establish trust there.

Beth also communicates her difficulties in setting boundaries and her sense of being let down by professionals. The following excerpt illustrates a pattern of self-destructive acts including suicide attempts which appear to be precipitated by threats of separation or rejection for Beth:

> *You look at that professional and think they know best so I actually took it that I was abnormal and there was something wrong with me and that brought my depression lower and I was a teenager I wasn't even of age, I was about 14 or 15 and then I took some paracetamol because I didn't think there was any other answers than to end your life (BETH, 153 - 158)*

With the absence of a caring, nurturing family, Beth looks to 'professionals' in the hope that they have the answers, but feeling judged and misunderstood leads her to feel there is something 'wrong with her' or that she is 'abnormal'. Unable to tolerate the unbearable feelings associated with her 'depression' and feeling rejected, she overdoses.

This section has explored some of the difficulties and stresses participants' experience in their relationships with others, from feeling unseen, to feeling unloved, criticised or judged. This difficulty in getting their needs met also highlights some of the challenges women face in therapy and the importance of the therapeutic relationship in providing a restorative relational experience, which could provide a healthy forum for expression and communication.

3.4.3 Stigma and Gendered Expectations

This final section explores sociocultural influences on the participants' experiences of treatment, considering how these impact on their sense of self-concept and relationship with others. I will examine the women's accounts of norms and expectations in relation to being female and having a gambling problem, including those of a cultural, societal and familial nature.

The data reveal an interesting mixture of experiences regarding norms and expectations. Most of the women acknowledged some type of norm or expectation but some felt more influenced by these than others and only four had experienced these in relation to treatment. Since this study sought to explore the 'female' experience of treatment, it was striking that most participants did not appear to see themselves as a minority, nor to focus on this aspect of their experience of treatment.

Amy sees the norm for gambling as being male-dominated and acknowledges the impact of this in terms of her sense of self and how she feels others perceive her:

> *You can see all the men in the bookies, down the horse races, you very rarely see women playing fruit machines with the men in the bar. I think it's predominantly a male thing which is why as a female doing it you feel even worse, you think there's something wrong with me. (AMY, 143 – 149)*

For Amy, the fact that she does not conform to the UK norm appears to be a great source of shame as she feels abnormal, as though there is something 'wrong' with her. This may be a product of societal influence and social construction but as she discloses her reluctance to allow her parents into her world of gambling, it appears these values may be deeper rooted on a cultural or familial level. She explains:

> *I wouldn't want my parents to know. Mum and dad don't know…it would be embarrassing. (AMY, 307 – 310)*

As Amy has communicated her shame and embarrassment about her minority status, it is understandable she imagines feeling 'out of her depth' at the idea of sitting in a treatment group with male gamblers, as though she does not deserve to be there. This resonates with her earlier narrative of feeling unimportant:

> *I think men would dominate it and I would feel a bit shy you know because they are more common and we are a bit rarer. I would feel a bit out of my depth, out of control, out of my depth, different. (AMY, 502 – 505)*

While Amy appears to feel under considerable pressure to conform to ideals and social norms, for Jacqui, being in the minority as a female gambler does not appear to faze her. Perhaps she feels more 'confident' in a female-free zone, given her difficulty identifying with women and preference for male company. She explains:

> *I never met any women gamblers on my, in my gambling career, I don't know if you call it that, I've never come across other women who were addicted like me, but I come across you know numerous men. (Jacqui, 15- 17)*

Beth and Catherine communicate their struggle to access adequate support, partly as a result of their gender. For these women, the rejection they have experienced while trying to access services appears more problematic. Beth elaborates:

> *I've never seen a female in recovery in a GA meeting…initially they look at you and they said you're female you should be in the partner's room, and I'm not a partner, I'm a gambler, I need to be in this room, so you get rejected a lot. (BETH, 181 – 185)*

Throughout Beth's narrative she portrays her long, uphill search to find help. She experiences being cast aside and dismissed at GA, it seems this rejection feels familiar for her as she protests that she wants to stay in the room and describes the way 'you get rejected a lot', distancing herself from the painful experience by narrating in the third person. Not only does she experience rejection from society but also from treatment centres where she is turned away. But unlike Amy, who appears to retreat into her own world of shame, Beth articulates her anger and keeps knocking on doors for help – she later became the first woman to be offered help at Gordon Moody. She explains:

> *I was so irate that they only offered treatment to male members only, it is disgraceful that in the whole of the UK you could only go private or if it's not private the only treatment centre was male only, there was nothing for women and that's kind of discriminating for problems and I was so, that's another thing, you know, rejection and that you just don't know where to go so I carried on gambling and I carried on NA meetings. (BETH, 225 – 231)*

Here Beth becomes 'irate' and expresses a grievance with the industry, moving away from her pain, yet she later acknowledges her sense of 'rejection' which for her leads to another gambling episode.

Like Beth, Catherine feels she had some difficulty accessing treatment due to her gender, but for her it was the childcare access that proved to be the main barrier to treatment as previously discussed in Section 3.3.2.. However she also makes a more general observation about treatment availability for gambling, comparing it to drug and alcohol addictions.

> *You can get help for drugs and alcohol but gambling there isn't much help in London (CATHERINE, 43 – 44)*

These experiences appear to be in contrast to younger participants, or participants who have been gambling for less time and could be interpreted as a contextual difference relating to age and changing cultural norms or treatment options. Alice does not perceive her gender to have impacted on her treatment experience, despite being prompted. Alice explains:

> *No, why should it (ha) all sorts of people gamble, don't they? There's no stereotype, is there? I mean look at them - they're all lonely people, I think? If you look at gamblers they are quite lonely? (ALICE, 175 - 178)*

In this short extract, Alice emphasises that 'all sorts of people gamble', firmly denying that there is any stereotype for gambling in relation to gender, yet she appears to relate more to the 'loneliness' that she believes is shared by gamblers.

Natalie hopes to meet fellow female gamblers. For her, being in the minority does not appear to be a source of inner struggle, yet she welcomes the idea of meeting others she can relate to. Natalie explains:

> *I was looking forward to being in a group a little because I thought I might meet fellow women that were gamblers and it would be nice to actually talk to other people who were gamblers. (NATALIE, 95-97)*

Emma acknowledges a 'stigma' surrounding gambling but she does not seem to feel ashamed to be gambling as a result of her gender. Like Catherine, she compares gambling addiction to drug and alcohol addiction. For her, the frustration appears to be linked with feeling misunderstood. She explains:

> *He (boyfriend) wasn't supportive in any way even though he's an alcoholic, even though he's got issues and I've supported him he couldn't understand, it feels like there's a stigma on gambling even in comparison to, I got told you're worse than a crack addict. (EMMA, 182 – 186)*

For Diane, while she does not appear to place much significance on being in the minority as a female gambler, it is clear from her narrative that she feels strongly about being independent, and financial independence appears to feed into this, as she makes frequent reference to 'having her own bank account' (134) and 'spending her own money'.

For Diane, having a gambling problem is associated with a loss of financial independence and choice, which is arguably undesirable for a 'modern female'. She explains:

> *I obviously lost a lot of money so I don't have the freedom you have in terms of choices in your daily life, urm maybe a bit less confident in certain things. (DIANE, 341 – 342)*

As she makes sense of her experience and feelings she communicates how this feeds into her value system and in this way it appears to impact on her sense of self. This is powerfully articulated in the extract below, in which her pain, isolation and helplessness are evident as she compares herself to her working, functioning partner. She explains:

> *I remember some days just, urm yeah you just feel like it's almost on the brink of a breakdown …..my other half would have been at work and so it was just, like really I can't even, it's hard to describe that, I think because it's like that's where the pain of it is. (DIANE, 199 – 204)*

This section has captured a diverse mixture of experiences regarding sociocultural influences and it has been possible to explore in some detail the impact of this on the treatment

experience for participants. Participants communicate a range of unique experiences and interpretations of these norms and expectations, which appear to both influence and be influenced by their sense of self and relationships with others.

3.5 Summary

In summary, the analysis has sought to present the key aspects of treatment experience for female problem gamblers. Through the participants' narratives, three master themes of loss, conflict and relationships emerged and within these main themes a diverse range of areas were introduced. Although unique for each participant, each area illuminated key aspects of their treatment journey and an overarching theme which spanned all themes, binding them together, was the impact of the women's relationships on their lived experiences. Participants were all familiar with an overwhelming sense of emptiness or loneliness, stemming from early damaged relationships or more recent losses and bereavements. Gambling appeared to fill this hole, enabling them to regain a temporary sense of control, yet the prospect of therapy threatened to remove this crutch, leaving a gaping open wound or an empty space. In their narratives, many conflicts around seeking help emerged; some of which were internal struggles linked to women's complex experiences of relating to themselves and others, while many practical blocks were also identified as barriers to treatment including distance and waiting lists, preventing women from readily accessing support during their time of need. Women portrayed a sense of ambivalence and splitting, communicating their confusing desire to 'be rid' of their gambling problem, while at the same time viewing it as a part of them, indicating a fear of success of treatment. Finally, the significance of not feeling understood inside and outside of the therapeutic context was communicated in all the narratives, as women portrayed their sense of feeling abnormal, different and isolated, highlighting the need for a more bespoke treatment experience. Therefore their treatment experiences were laden with hope and reward, but also fear and disappointment, driven by the complexity of their relational dynamics. The role of their gender in this overall treatment experience had mixed significance for participants. This will be explored in the Discussion Chapter.

CHAPTER 4 - DISCUSSION

4.1 Summary

In this Discussion Chapter, after restating my research aims, I will review and explore the themes which emerged from the participants' interviews, identifying connections between them, discussing their meanings and using existing literature to support and further examine my interpretations of their narratives. Master themes will be explored in the same order in which they appeared in the Analysis Chapter. Following a full discussion of the themes, I will examine the strengths and limitations of this study, and consider areas for future research, before making recommendations for treatment for female problem gamblers based on my findings. I will subsequently discuss the significance and implications for clinical practice in Counselling Psychology. Finally I will make some methodological and personal reflections, before concluding.

The present study aimed to illuminate the lived experience of treatment for female problem gamblers. It hoped to answer the following research question:

- How do females experience treatment for problem gambling?

In addition I hoped to address the following questions on the basis of my findings:

- What factors are impacting on the experience of treatment for females seeking help?
- What are the treatment needs of female problem gamblers?
- What are the barriers to seeking help for female problem gamblers, if any?

Results suggest that the treatment journey for women is a complex, multifactorial process, with many psychological, interpersonal, historical and contextual dimensions influencing their experience.

4.2 Main Findings

4.2.1 Running from the Pain of Loss

A prevailing sense of loss echoed throughout the experiences as each of the women portrayed overwhelming feelings of emptiness, which could drive participants back to gambling, leading to further loss. At the time of the interviews, half the participants were still gambling despite intervention and the remaining four participants were ambivalent and uncertain about abstinence in the future. While the interview schedule did not contain specific questions exploring loss, separation, neglect, trauma or death, descriptions of varying types of loss and how this linked to participants' gambling behaviour and treatment experiences permeated all of the accounts. In this way, loss appeared pivotal to the women's experiences. Consideration of this phenomenon led me to go back to the literature and further investigate loss and grief. The following section therefore aims to further understanding of how the experience of loss impacts on the treatment experience for female problem gamblers.

Deep feelings of emptiness and loneliness associated with early loss, such as neglect or abandonment, were communicated by four participants. A desire for closeness with others for these participants seemed to be constantly clouded by a terrifying anticipation of further rejection or abandonment; a push-pull dynamic in their relating was observed. Psychodynamic theories and in particular attachment theory may help shine some light upon the present study's findings and provide a framework for understanding how early interactions with primary caregivers can influence our experience of relating in adulthood. Bowlby (1979) purported that the way a child is treated or responded to by her parental figures can have a profound influence on their development. Research indicates adult relationships are influenced by unconscious processes originating in early childhood through internal working models (Bowlby, 1988) and in the neurobiological development of the brain (Schlore, 2001). A child's early attachment experiences therefore form the building blocks of her emotional, and social world. If care-giving is inconsistent, abusive, or dysfunctional – as experienced by several participants in this study –the child's attachment behaviours, including the ability to form adult relationships in which needs can be met, become disrupted and a disorganised attachment may be the result (Bowlby, 1979). Such experiences can result in declining cognitive performance and

personality disturbances. The capacity for empathy, reflective self-functioning and mentalization – the ability to think about our own and others' mental state (Bateman & Fonagy, 2006) - may be reduced. The development of the neuronal structures which help regulate emotion can be hampered (Blum, 2003; Fonagy et al., 2004). Reading (2002) asserts that clients' relationship with gambling may be seen as having some similar characteristics to those demonstrated in interpersonal relationships. This is supported by participants experiences of becoming 'attached' to their gambling and the anxiety expressed at the thought of giving it up, despite acknowledging its damaging potential. This also helps to explain the ambivalence that was observed in many participants. According to this theory, gambling provides a replacement for what is missing in their lives. Reading (2002) goes on to suggest that attempts should be made to enhance the patients' ability to locate their symptoms in an interpersonal context by creating a 'secure base' in the therapy space in which clients may form a healthy attachment to the therapist, rather than their gambling. Yet the potential for this is limited during a cognitive-behavioural therapy (CBT) intervention of only eight sessions.

Many participants expressed a fear of ending therapy and uncertainty about the future. Beth seemed terrified of looking forwards or backwards, but felt contained by her current therapy episode and the structure it provided. For Catherine, ending each session of therapy was anxiety provoking, and she felt she needed continued support between sessions. Emma expressed a desire to continue with more sessions, despite feeling the benefits of her treatment episode. Questions of sustainability of therapy are important here, yet to date, there is limited research which looks at the relationship between the number of counselling sessions attended and outcomes for problem gambling treatment. Somewhat surprisingly Dowling and Cosic (2011) found that there was no significant relationship between number of sessions and gambling or general functioning outcomes. While the question of how much treatment is required has important implications for service providers, funders and clients, this study demonstrates the complexity of the relationship length and outcome across multiple clinical domains. Participants may be afraid of not just failure but also successful treatment, since this may represent the end of both gambling and treatment.

Five participants described bereavements during their interviews which they associated in some way with their gambling behaviour. Two participants felt they needed 'bereavement therapy' to focus on these losses, as they viewed gambling as a secondary problem. While the experience of grief was different for each participant, some conclusions may be drawn from these descriptions, as it appears these participants felt so overwhelmed by their grief that they resorted to maladaptive behaviour, or gambling, which may be viewed as part of an 'abnormal

grief process'. Lazare (1979) sheds some light on this, proposing that self-concept may hinder grief, for example for someone who perceives themselves to be the 'strong one' in the family, it may seem impossible to allow herself to experience the feelings necessary for an adequate resolution of loss (cited in Worden, 2010). Simos (1979) explained 'since the resolution of grief demands the experiencing of universal feelings of helplessness in the face of existential loss, those individuals whose major defences are built around avoidance of feelings of helplessness may be among those likely to have dysfunctional reactions to grief' (Simos, 1979, p. 170). Boyd and Bolen (1970) from the psychodynamic school of thought proposed that loss was a prevalent theme for gamblers, asserting gambling may represent a 'manic defense manouvre' to temporarily distract individuals from loss and trauma. The narratives of the women in this study revealed how helplessness was experienced in the face of loss. Natalie found it difficult to ask for help and seemingly wanted to appear strong and in control, she felt rage at her mother's death, as though unable to process it. Jacqui, who gambled away her parents' inheritance, felt guilty, hoping to be 'redeemed' through therapy. Meanwhile Alice felt the burden of her sick relatives as she took the role of carer – neglecting her own needs - while one by one they passed away. While each woman's experience was unique, they shared a common thread in that it appeared they have not found the space to grieve or process their emotion. This brings up many questions regarding the therapeutic focus for these participants and the extent to which loss should be explored and processed within sessions. I was unable to find any research which has focused on the relationship between bereavement and gambling, but this is an important area for future research.

The experiences of the women in this study reveal a particular tendency to gamble to 'escape' difficult feelings, including boredom or loneliness, and in this way to 'run from the pain' and the emptiness they experienced. These findings are consistent with research that women prefer to play easy games, or games of chance rather than skill, such as fruit machines and bingo (Holdsworth et al., 2012; McCormack et al., 2014, Potenza et al., 2001; Volberg, 2003; Svensson et al., 2011;). These types of games, which serve as a distraction, allow women to switch off, experiencing various states of dissociation and feelings of escape. Bingo also facilitates social involvement, which may help alleviate feelings of loneliness. The most popular choice of gambling activity for women who participated in this study were fruit machines and gambling online. All participants described how they would gamble to escape their difficult lives and emotional states. Catherine was in an abusive relationship and gambled following a spate of deaths. Alice gambled to escape her 'misery' and the pressure of life. Natalie gambled when she felt ignored, or angry. Amy gambled to relieve her boredom and monotonous life. Beth gambled when she felt suicidal, and that there was no hope. Wood and Griffiths (2007) can

shed some light on this as they looked at the extent to which men and women used gambling as a means of coping. Escape was the prime characteristic of the gambling experience that facilitated the continuation of problem gambling among the 50 interviewed participants. They found motivations driving the need to escape included: mood modification needs, filling the void and avoiding problems. This shows how difficult it may be for some of the participants to regulate their emotions. Some women could therefore benefit from therapeutic interventions to help them learn that they can survive or tolerate difficult feelings. While for others who are not ready to focus on emotional aspects of their being, filling the void through more solution-focused endeavours, such as taking up new hobbies, learning new skills or joining special interest groups may help to sustain them and provide meaning in their lives post therapy.

Some participants appeared to display traits of Emotionally Unstable Personality Disorder (ICD-10, 2015) or Borderline Personality Disorder, such as impulsivity, unstable relationships, feared abandonment and unstable sense of self (Lynam & Widiger, 2001 cited in Geiger et al., 2013). Whilst not wishing to pathologise the participants who took part in this research, it seemed important to tentatively explore this finding. Further investigation revealed a body of research, which will be described below, linking personality disorders to problem gambling. Odlaug, Schreiber and Grant (2012) note that personality disorders appear to be common in problem gambling and may contribute to the chronic problems often associated with the disorder. This finding is important because working with clients presenting with traits of personality disorder may present further challenges for treatment; for example alliance ruptures and premature endings due to the client dropping out of treatment are common (Bennet, Parry & Ryle, 2006 cited in Daly et al; 2010). Therefore careful consideration should be taken as to the most suitable intervention for problem gamblers presenting with these traits.

4.2.2 The Conflict of Seeking Help

Conflict was manifested in the accounts provided by all participants as they experienced internal and external battles in relation to seeking and receiving treatment for their gambling problems. Essentially, participants reflected that their journeys were full of sadness, loneliness, helplessness, fear, shame, guilt, anxiety, anger, segregation, confusion, desperation, frustration, reward, empowerment and relief.

I will firstly focus on some of the internal struggles, such as denial, fear, stigma, rejection which were prevalent in relation to becoming a patient. Treatment is a daunting prospect which requires commitment and honesty, acknowledging failings, vulnerability and emotional states

that women in this study have been avoiding. Paradoxically gambling provides an escape route from these states, as well as offering the hope of solving financial difficulties through winning money, lulling women into a false sens e of control of their problems. The participants' narratives revealed an ego-dystonic struggle. The Penguin dictionary of psychology defines this as 'wishes, dreams, impulses and behaviours, that are unacceptable to the ego'; for example Jacqui, Amy, Natalie, Diane, Alice and Catherine continued to experience dreams, thoughts and compulsions to gamble, despite their wish to stop gambling and prior engagement in therapy, indicating ambivalence to stop gambling.

Participants reflected that they were either motivated to seek help for their gambling problem because they were desperate, had hit 'rock bottom', or in other words had experienced an 'existential crisis', believing things could not get any worse. Others were encouraged to receive support by their partners or family members. It emerged that for some participants in the present study, exposing their vulnerability was another barrier to treatment; Diane, Natalie and Emma expressed their reason for not seeking help sooner was a wish to 'handle the problem' themselves. As far as I know, there exists no data which specifically examines gender-related differences in motivation to enter treatment, however studies show that problem gamblers are unwilling to admit their problems and generally present for treatment when the severity of their difficulties drives them to therapy as a last resort, supporting the findings in this study (Evans & Delfabbro, 2005; Suurvali et al. 2008; Tavares et al. 2008 cited in Gainsbury et al, 2014). Interestingly, Avery and Davis (2008) found that women are more likely than men to be motivated to stop gambling to resume their cultural role of care taking and relationship tending, which further supports the experiences of the women in this study, and could help explain their motivation to seek help. Rodda, Hing and Lubman (2014) reported that women were more likely to contact a helpline for support with their gambling due to problems associated with the welfare of others and/or their living arrangements. These factors combined, bring to light important considerations for service providers regarding 'readiness for treatment' for those women that have come forward for help.

Ambivalence can be a principal obstacle in facilitating change and may also help explain high attrition rates and low numbers of women presenting for support at the [redacted], 2013). Findings of most attrition outcome studies indicate high rates of treatment attrition whereby as many as half of the individuals seeking treatment for problem gambling will terminate before completion (Ladouceur et al., 2001). It therefore seems important to establish what conditions need to be present for an effective intervention, and how to help women overcome these internal struggles to enable them to access and utilise available

treatment. Motivational interviewing (MI, Millner & Rollnick, 2002) is a 'person centred' way of addressing ambivalence about change in which the therapist may facilitate the client's expression of both sides of their ambivalence and guide them towards a more acceptable resolution which may assist them in triggering change; in this way it is a collaborative approach to help strengthen a person's own motivation and commitment to change. Hodgins et al. (2004) showed participants who received a motivational telephone intervention plus a self-help workbook were more likely to be classified as improved for gambling problems than those who received only the workbook with no intervention, supporting the idea of a motivational intervention. Yet treatments for gambling problems are not well-established and there is limited research that demonstrates which types of treatments are effective.

The experiences of the women in this study also revealed many external, practical difficulties associated with accessibility of treatment. For example, Catherine, Alice and Beth described distance as a barrier to treatment. Rigbye and Griffiths (2011) argue that recommendations made by the British Medical Association have failed to be realised since treatment centres are not readily available within localities and therefore the needs of problem gamblers are not being met, supporting these findings and indicating this is a wider spread problem. Other barriers to treatment which emerged in all of the participants' narratives included long waiting lists, cost of travel, inconvenient times for after care groups, childcare issues and a lack of information and awareness among professionals and GPs. These reflections emphasise the importance of convenience, flexibility and accessibility to treatment as well as education and awareness of treatment options for problem gamblers, in order to engage this population - especially given the internal obstacles they must also overcome as previously discussed. For example, Diane described how difficult it was to ask for help, yet when she came forward, help was not readily available and she experienced the 'waiting' as distressing, highlighting how critical timing of the intervention can be. Likewise, Emma and Natalie discussed their experience of waiting to get help as being a negative aspect of treatment, resulting in more gambling and losses. A recent study by Linnet and Pederson (2014) supports this finding. They found that waiting time from initial contact to the first session with a therapist was a significant predictor of risk of attrition for problem gamblers. Longer waiting times were associated with increased risk of attrition. Given the difficulty engaging problem gamblers in treatment in the first place, this has important implications for treatment and emphasises the need for more services and support for women with gambling related problems which may help reduce waiting times (Productivity Commission 2010).

With the rise of technology, new options are becoming available for treatment which address some of these barriers to treatment and accessibility issues. In the present study, Alice was offered 'remote' treatment since she lived far away from the [redacted] She reported this to be beneficial and that it enabled her to engage in treatment. Emma also reported benefiting from online forums for problem gambling prior to accessing treatment. Catherine was disappointed at being unable to attend the post-treatment meetings due to distance and childcare issues. These cases provide some evidence for the potential benefits of 'virtual' or remote therapy, helplines, online support groups or local meetings. Wood and Griffiths (2007b), Rodda and Lubman (2013), Rodda, Lubman, Dowling and Jackson (2013), and Rodda, Hing, and Lubman (2014), shed more light on this with their studies on web-based services and helplines. Wood and Griffiths (2007b) evaluated the effectiveness of an online help and guidance service, GamAid, finding that the service appeared to be one of the few international guidance and 'counselling' services available to problem gamblers. Other main findings were that gambling online was the preferred form of gambling for most of the GamAid clients, the service was favoured more by women than any other comparable service and overall clients were positive about their experiences using the service. Rodda et al., (2013) found that web-based counselling can address common barriers to treatment, including issues of shame and stigma. In their study, 222 participants provided 351 reasons for using online counselling which fell into four broad categories: (1) confidentiality and anonymity, (2) convenience and accessibility, (3) service system access, and (4) therapeutic medium. This may help inform the development of targeted online campaigns, however it does not illuminate much regarding gender differences. Rodda et al., (2014) highlighted the importance of helplines as a key support for both male and female problem gamblers.

Another predominant theme among all participants was the desire for a more bespoke treatment experience, implying that the CBT intervention was not tailored enough, or did not meet their individual needs. For some women, it did not pay enough attention to the therapeutic relationship since those participants did not feel as though their difficulties were fully acknowledged. There was some concern expressed by all participants around being forced into a 'box', since aspects of treatment were not relevant for them. Natalie, Amy, Emma, Diane named aspects of therapy which they felt were unhelpful, leading them to select the most useful bits to take away. These common criticisms of CBT as a prescriptive, theoretically heavy and technique-oriented approach to treat ailments with a specific diagnostic criteria, organically emerged from the data. This could be said to contradict findings by Dowling et al (2006a), who evaluated the efficacy of CBT for the treatment of female problem gamblers in Australia, concluding that CBT is an effective treatment for female problem gamblers, as participants

showed significant improvement in gambling behaviour post treatment. However this discrepancy could be explained by the fact that the current study approached the data from a different perspective. As a qualitative study, it does not seek to measure efficacy but instead to gain a sense of participants' experience through semi-structured interviews, allowing for the emergence of a more detailed account which may illuminate specific details of the overall treatment experience including some aspects which are less helpful and more helpful.

Elements of the model which some participants rated highly, included 'doing' therapy in a supportive working alliance. Emma and Alice reported benefiting from and feeling empowered by mindfulness techniques. Further investigation of mindfulness and problem gambling revealed this has gained the attention of researchers across Australia, the United States, and Canada in recent years (de Lisle, Dowling, & Allen, 2012; Shonin, van Gordon, & Griffiths, 2013). Chen et al. (2014) in Canada, looked to evaluate the feasibility of teaching problem gamblers about mindfulness meditation as part of regular treatment for problem gambling. The results indicated that mindfulness was successfully taught during the eight-week group program. However, the study did not evaluate whether mindfulness improved the clients' ability to resist relapse. De Lisle et al. (2012), reviewed literature with respect to mindfulness and its potential for reducing the severity of problem gambling behaviour. While mindfulness interventions were found to have the potential to improve outcomes and psychological distress for a wide range of gambling-related issues, they concluded that the approach should be considered with 'cautious optimism' due to insufficient evidence or comparison groups. Furthermore they failed to consider what this means for female problem gamblers specifically. More research needs to be done in this area.

The educational aspect of therapy was perceived positively by seven participants, yet some of the women describe being 'taught' or 'led' by the therapist, viewing themselves as 'pupils' or 'students' suggesting it was not a fully collaborative experience. In examining the participants' overall narratives, I wondered whether CBT was able to facilitate emotional processing for those participants who displayed high levels of avoidance. Boucher (2006) sheds some light on this as she proposes CBT can be understood on a 'continuum of application', which depends on three factors, including the practitioner's personal style, orientation and context (Boucher, 2010, p. 157). She proposes that if attention is paid to 'being with' an individual rather than 'doing to' as In the more manualised application of the method, the model can 'envelop the contours of their unique and valid experience' (Boucher, 2010, p.156) and in this way the model is experienced by the client as less prescriptive. This highlights the importance

of the application of the model for individual clients, depending on their personal preferences and style of relating.

4.2.3 Negotiating Relationships

Relationships was a central theme for all the participants throughout the interviews, permeating each of the three master themes. The following section focuses on specific aspects of relationships, including the way female participants relate to themselves and to others, aiming to demonstrate the pivotal impact that relating has upon their experiences of gambling and treatment. The resounding communication throughout all of the dialogues suggests that present relating is inextricably bound to past experiences.

Crucially, the narratives of the women in this study denote their sense of being 'different' or 'abnormal'; linked to this was their desire to feel understood and accepted, which was portrayed by fears of being judged, misunderstood, or pigeon-holed. All women emphasised how their 'type of gambling', or the way they gambled was different from others in some way. Emma articulated her concern about being categorised with other problem gamblers, Jacqui, Diane and Natalie expressed the importance of having a therapist who had been through the same experience so as to feel better understood and to avoid judgement, while for Catherine, the worst part of being a problem gambler was feeling as though she was 'not understood', even by professionals. The experiences of women in the present study bring to light the debates around problems with diagnosis, classification and categorising of those who gamble problematically, highlighting the complexity and multifactorial nature of the phenomenon of problem gambling. In terms of treatment approaches, these comments support moving away from a 'one model approach' and instead working holistically, taking into account bio-psycho-social factors. This is supported by Blascenszcnysky and Nower (2002), who proposed a 'Pathways Model' which identified three main subgroups of problem gamblers in an attempt to recognise the role and implications of vulnerability features, demographic features and aetiological processes present in problem gamblers. According to this model, the 'emotionally vulnerable' subgroup of gamblers present with pre-existing co-morbidities, and are more likely to gamble to escape negative emotions associated with pre-existing difficulties. This subgroup is characterised by psychological dysfunctions and is more resistant to change, therefore an individualised treatment is required. It could be argued that women in this study fall into this sub-group, as all participants reported gambling to 'escape' their negative emotions, however I would argue that even using a multi-pathways model could risk categorising gamblers in some

way. Griffiths (2005), has also proposed a more 'eclectic' approach to understand problem gambling which combines ideas from different perspectives in order to overcome limitations of individual perspectives.

Another implication of these findings is that groups may be beneficial for women, to help to foster a sense of community, and a forum in which women may share their experiences with fellow female gamblers. Diane, Natalie, Catherine, Amy and Beth all expressed an interest in participating in an all-female support group so as to share their experiences with other women. Literature from a myriad of disciplines suggests that social support is vital to physical, fiscal and mental well-being (Alloway & Bebbington, 1987, cited in Milton 2010). Being accepted within a group is a basic human need. This is echoed by Karter (2015), who emphasises that lifelong recovery for female problem gamblers requires more than just to stop gambling. She highlights the long term benefits and support that can be provided by women's groups, central to which she claims is an opportunity to face and cope with 'real life situations and relationships' (p.3). The preoccupation women demonstrated around feeling misunderstood also highlights the need for more education among service providers, treatment centres, GPs and gambling venues about what it means to be a problem gambler, to help avoid uninformed assumptions or judgements by others which could exacerbate their sense of loneliness and rejection, ultimately leading back to more gambling. This lends further support towards a public health approach (Wardle et al., 2011b) which could change public perception and enhance understanding through education. Only one qualitative study in Canada appears to have looked at the experience of all-female group counselling for problem gambling (Piquette & Norman, 2013), finding that women found women-only groups to be helpful and showed a preference to women-only groups in future. Dowling et al. (2006b) compared individual and group CBT for women, finding that both formats produced comparable outcomes in terms of gambling behaviour, however the group treatment failed to produce superior outcomes to a control group in relation to several measures of psychological functioning. It is proposed that caution should be applied when delivering CBT in a group format for women until further research is conducted to establish efficacy. However this only considers CBT treatment and fails to take into account complexities associated with the overall treatment experience from a relational perspective due to its quantitative methodology. It highlights further questions around suitable models of therapy for women.

The females' experiences revealed a world where relating to others could be daunting or frightening. To protect themselves, many women, including Diane, Emma and Natalie appeared to wear a protective mask, in this way keeping others at a distance, instead using

gambling to ease their inner pain and turmoil, creating an illusion of control. For others, including Catherine, Beth, Alice and Jacqui, it appeared they felt more dependent on others, as though they needed more reassurance to help manage their affect, or were less able to think about their own and others mental states when faced with separation. In this way it seemed some women had difficulties setting their own boundaries in relationships or in the therapeutic context. Whether they kept others at a distance, or close, each woman found it difficult to get their needs met since their inner voices appeared to be suppressed in some way. Karter (2015) supports these findings, proposing the underlying motivation for gambling in women is always found in relationships, whether it is 'too much' or 'not enough' (p. 1). There are several implications for treatment. Firstly, the therapeutic relationship is of paramount importance for this population, as it has the potential to be a restorative experience and offer a place of safety, consistency, boundaries, which some of these women have never experienced before. Most therapeutic models see the therapeutic relationship as one of the main tools for achieving client change (Luborsky, 1994 cited in Milton, 2010). Beck reminds us that when therapeutic rapport is optimal, the patient and therapist feel secure and reasonably comfortable with each other. Neither is defensive, overly cautious, tentative or inhibited (Beck et al., 1979, p. 51, cited in Milton, 2010). This view is supported by the following empirical work. Dowling and Cosic, (2011) found that the therapeutic relationship is an active ingredient of change in psychological interventions for problem gambling. Smith et al. (2004) further supports this with the finding that the therapeutic alliance had the strongest predictive power with respect to the level of problem resolution achieved by clients in therapy. The experiences of women in the present study also lend support to teaching assertiveness skills to help women get their needs met, especially those with a tendency to please others. Finally, at the root of these difficulties in relating to others lies a place of fear, vulnerability and helplessness which remains unacknowledged. Therefore teaching women emotional regulation and helping them to learn to sit with difficult feelings may help reduce impulsive behaviour such as gambling. Yet without basic trust in the therapeutic relationship, this will not be possible.

A poignant finding of this study was that most women didn't appear to consider themselves to be a minority as female problem gamblers, or at least they did not appear to be distressed by the prospect of this. It was interesting to note that those women who were older, or who had been gambling for many years, including Beth and Amy, felt more stigmatised than other participants, both in the gambling context but also in the therapeutic context; in treatment centres and groups where they felt 'rejected' and as though there were not as many options for them compared to men. Those women who were younger or who had been gambling for less time did not appear to experience a 'gendered effect'. Wardle's (2015) findings serve to

support this, as she proposes a ‘re-feminisation’ of gambling, suggesting that women are gambling more due to greater accessibility of facilities, noting there has been a shift in attitudes toward female gamblers. This provides important information for service providers, serving yet another reminder that each case needs to be carefully considered rather than generalising or lumping problem gamblers together as one homogenous group. For example some women might have experienced stigma and rejection, but this may not be universal.

4.3 Strengths and Limitations of the Study and Future Research

There were a number of both strengths and limitations identified in this study. Perhaps the most apparent limitation was the small scale of the study. Only focusing on one NHS outpatient clinic with a specific way of working may not have yielded analogous results to other treatment centres. Since no other study of this kind currently exists in the UK it is not possible to ascertain whether findings are typical. More research is needed in the same area in order to substantiate the current study and enhance reliability. It would be useful to conduct the study on a larger scale, across a range of problem gambling treatment centres in the UK as well as non-specialist settings to determine whether perceptions of treatment differ according to other elements. This study could also be done on an international scale, taking into account contextual factors. This would add to the findings from this small scale study and inform treatment providers. Further studies should also explore different models of treatment since research currently seems dominated by CBT for problem gambling and therefore does not represent the full spectrum of recovery models. This would require a large investment of both time and resource but it could contribute towards making the experience of treatment more worthwhile and therefore would be deemed cost-effective.

Another limitation to this study was the absence of a male comparison group, which precludes forming conclusions on gender differences in the experience of treatment for female problem gamblers. While my intent was to focus on women, to address a gap in the literature, in doing so, I have missed out on additional information which could have been provided by males. Future research on males’ perspectives would be valuable either in conjunction with, in comparison to, or separately from studies investigating women’s treatment experiences.

Several sample limitations were identified. Firstly, those participants who volunteered felt able to speak about their difficulties, however some women did not respond to the invitation to participate; perhaps those women were still struggling to cope with their problems. It would be useful to look at the problem gamblers who were actively struggling with their gambling, or had

dropped out of treatment. However, this population may be more difficult to reach. Another sampling issue that emerged was that the group of women who were interviewed may not have been homogenous enough. For example, some women had previously had treatment while for others this was their first time. The age of those women who were included in the study was not factored into the data, but it was evident from the narratives that it had impacted greatly on their treatment journeys and the way they perceived their gambling problem. Participants had not all had the same number of sessions and some were nearing completion of therapy while others had completed therapy. It is interesting to note that only one of the participants was a mother, which may be a contextual factor bearing in mind the study took place in London. For a more reliable study, the group needed to be more homogenous.

Problems with the definition and classification of a gambling disorder could be viewed as problematic. The women I spoke to participated in a range of different types of gambling, in different ways, with a preference to gamble in different locations, for different time periods and for different reasons. Some also described varying co-morbidities prior to the onset of problem gambling. As previously discussed, individuals who gamble problematically should not be placed into one group in this way. Therefore, it could be argued I was speaking to a group of eight participants with a range of problems. On reflection, I could have measured their gambling severity prior to the interview, as well as trying to ascertain other differences and similarities, in order to select a more homogenous group, since this would impact on findings.

Several methodological limitations were also identified. While IPA can provide a detailed picture of a participants' experience, which reflects the complexity of this experience and its embedded nature in the individual lifeworld, it cannot explain social processes and it does not assume generalisability. Alternative methods to consider for future studies include mixed methods and grounded theory. A grounded theory study may have provided a greater understanding of the high attrition rates at the [redacted], explaining some of the processes behind this phenomenon and it could go further to explain what is going on, generating new theory. This may also help shed light on how women come to the decision to engage in therapy, or what it is that stops them from coming forward for help. Using a grounded theory approach would assume that data is out there and there is a need to find it, in this way it could be argued that categories are constructed by the researcher and that conceptual frameworks or theory can be developed based on data that is gender specific. Unlike IPA, It claims to be generalisable based on theoretical saturation. A mixed methods study would have created more robust findings, enabling a quantitative comparison between male and female problem

gamblers in treatment in addition to the more detailed qualitative exploration. Time limitations and practicalities deemed these methods inappropriate at this time.

I would argue that key strengths of this piece of research were that it was timely, original and responded to a current need on behalf of service users working with problem gamblers. Stakeholders were involved and interested in the development of this study, which has also received high levels of interest from experts working within the field of problem gambling. The research provided female problem gamblers with an opportunity to tell their story and have their voices acknowledged. This has been achieved through the "detailed and inductive approach of IPA, with its roots in phenomenology and hermeneutic enquiry" (Eatough & Smith, 2006, p. 496). To date there has been a lack of focus on individual experiences of problem gambling or treatment, reflected in the predominantly quantitative nature of the existing body of research. Very few qualitative investigations have been conducted. I propose that future research is conducted using qualitative methods, so as to capture the intricate nature of how people perceive and evaluate their experience in a socio-cultural context and how they make sense of and give meaning to their experiences. Future research may gradually build a picture of this phenomenon from a broader perspective to enable movement to a more universal understanding (Eatough & Smith, 2008).

Since there is such a vast gap in the literature in the UK on problem gambling, there is a wealth of research which services could benefit from. It would be useful to carry out more research on clients' motivations to change and how this can affect the treatment experience. This may help provide some insight into whether the treatment experience is more or less manageable based on certain motivations and help to clarify where the motivation to change comes from. Is it connected to relationships or desperation as identified in this study, or is there a more personal impetus which increases the desire for a woman to stop gambling? Likewise it would be useful to learn more about barriers to treatment for female problem gamblers in the study, to add to the existing, growing body of international research which has investigated this topic. It cannot be assumed that British problem gamblers have the same presentation and aetiology of development as those from other countries, therefore further research is required on a national level. An exploration of attrition in female problem gamblers would be extremely informative, however for a detailed exploration of this topic, and to understand the phenomenon more completely, interviews would need to be conducted with women who had dropped out of treatment or those who had not yet engaged in treatment. Gaining access to this hidden population is likely to be more complicated, since arguably if these women are ambivalent about treatment, they may also be ambivalent about participating in research. The

recruitment sample pool and methods would need to be expanded to online forums, and the defining factors of having a gambling disorder would need to be explicitly defined.

With respect to learning more about the notion of attachment and trauma, findings from the present study highlight that more research is needed on bereavement and gambling and also on trauma and gambling. Had I known the research would illuminate these links, I might have incorporated an attachment questionnaire as part of the study, to further explore this.

While many findings have emerged from this study, the more we know, the more questions are raised, creating further need for research. Vassilev and Pilgrim (2007) remind us: 'there is no single theory that can tell us everything about a phenomenon; the best we can hope for is to zoom in and change the angles of our observation to improve our understanding' (p, 350). It is hoped that by focusing on this particular aspect of women's experience, psychologists and professionals working with this group may have a clearer picture of treatment needs and challenges. I hope the findings of this study will provide some suggestions for future practice.

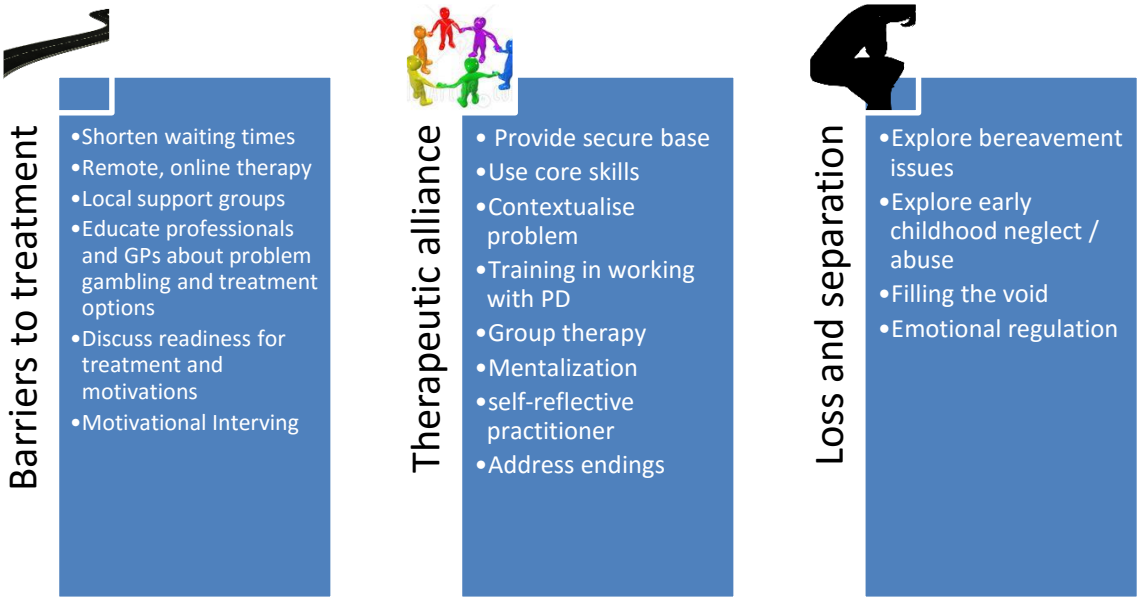
4.4 Summary of Treatment Recommendations Based on Research Findings

Below I have highlighted recommendations for treatment based on the findings of this study. As noted in the previous section, this small scale study cannot be generalised to all female problem gamblers, but merely seeks to offer some insight into this small group of women who have been generous enough to share their treatment experience; it therefore seemed helpful to clarify and summarise findings into the below recommendations for ease of access, which also includes a picture illustration:

- **Address ambivalence:**
- Discuss and ascertain readiness and motivations for treatment.
- Consider Motivational Interviewing (MI) if ambivalence is identified
- **Address accessibility issues:**
- Shorten waiting times
- Offer an option for remote, online therapy or local support groups
- Provide online forums for women to keep in touch with each other during or post treatment to provide a group or community in which they can belong
- Educate and inform GPs and other professionals of issues surrounding gambling problems and treatment options
- **Working with loss:**

- Explore bereavement issues
- Help fill the void
- **Emotional regulation:**
- Learning to help tolerate difficult feelings
- Teaching self-reflectivity (or mentalization based therapy)
- Teach mindfulness skills
- Assertiveness skills training to help women communicate their needs
- **Focus on therapeutic relationship**
- Use core skills
- Provide a ‘secure base’
- Create ‘narrative context’ to contextualise problem
- Group therapy
- Working with endings
- Self-reflective practitioner
- Training in working with ‘personality disorder’
- Individualised interventions

Picture 1: Treatment Recommendations for Female Problem Gamblers



4.5 Implications for Counselling Psychology Practice for Individuals with Gambling Disorders

4.5.1 Significance for Counselling Psychology

Advertising, availability and access to gambling are increasingly prevalent following the introduction of new gaming regulations. Therefore, Counselling Psychologists and services in the UK need to be prepared for an anticipated increase of individuals presenting with gambling related problems. This cannot be managed effectively without an appropriate research base to expand our understanding of the condition. It is hoped that findings from this study will inform Counselling Psychologists about how to work with this population. The theoretical review of evidence indicates that therapeutic interventions can be helpful in reducing the severity of gambling problems and improving psychological wellbeing in individuals with gambling related problems (Ladouceur et al., 2001; Lopez Viets, & Miller, 1997 cited in Dowling & Cosic, 2011). In 2007 The British Medical Association (BMA) proposed the NHS should provide sufficient support for gambling disorders. Yet female problem gamblers presenting for treatment remain significantly underrepresented in research with most studies focusing on male samples. Consequently little is known about how to engage this population. Furthermore there are indications that female problem gamblers are underrepresented (compared to males) in UK services, for example only 7% clients presenting for treatment at the [redacted] are women. More research needs to be done to ascertain whether this trend is true on an international scale. The implications of this study are, therefore, of particular interest and significance to Counselling Psychologists, since they aim to generate knowledge which can be applied to clinical practice in a range of settings.

4.5.2 A Pluralistic Stance

Crucially, Counselling Psychologists take a holistic approach to understanding the development and maintenance of human distress (Du Plock, 2010) and use formulation and co-operative enquiry to facilitate this (Milton, 2010). This helps to locate clients' behaviour and experience within a biographical, developmental and social context to fully understand how the difficulty is being experienced. The present research has discussed the complexity involved in the categorisation of problem gambling, illuminating an important point for reflection around the process of categorisation and its attempts to impose sense on the environment in which it finds itself (Haslam, 2000, sited in Woolfe et al, 2014). For the women in this study, it quickly

emerged that they considered themselves and their difficulties to be unique, and it was their wish to be treated this way in the therapeutic context, rather than lumped into a group with other gamblers, supporting a more bespoke treatment experience. Based on the data derived from this study, psychologists are advised to carefully explore these socio-cultural factors, placing women's narratives into context, taking into account the worldview of the client, with a view to offering a more individualised approach. Our understanding of an individual cannot be separated from an understanding of the context (Mearns & Cooper, 2005). Understanding the socio-cultural contexts in which gambling occurs may help to challenge and breakdown the prevailing cultural discourses of problem gambling. Furthermore an understanding of the heterogeneity and complexity of female problem gambling highlighted in this research, may enable Counselling Psychologists to be mindful of and to challenge existing addiction discourses within their practice.

With this holistic perspective, Counselling Psychologists are encouraged to deploy a pluralistic stance, to tailor the therapeutic encounter to the individual's uniqueness in the here and now. Cooper and McLeod (2007, p.6) remind us that 'different explanations will be true for different people at different points in time and therefore different therapeutic models will be most helpful for different clients at different instances' (cited in Milton, 2010). Counselling Psychologists are therefore encouraged to draw on their expertise from different paradigms, based on humanistic, existential / phenomenological, psychodynamic, cognitive behavioural, narrative, systemic and social constructionist traditions to further enhance understanding for and of these women.

4.5.3 A Restorative Relationship

Counselling Psychologists traditionally see the therapeutic relationship as the most powerful therapeutic medium (du Plock, 2006, cited in Milton 2010). This relational framework highlights the intersubjective nature of human experience. In this way it promotes a 'relational stance', placing the therapeutic relationship with other people at the forefront of their practice (Division of Counselling Psychology, 2004 – 2005 cited in Milton, 2010). The experiences of all of the women in the study highlight the central role that relationships play for them, and for many there was evidence of difficulties in interpersonal interactions, with histories of neglect, abuse and loss. Participants felt misunderstood by others, as though their communications were unheard or unseen, resulting in the continuation of unmet needs. Whilst this has been discussed earlier, I would suggest that much must be learned and that this is of particular importance with regard to service provision for female problem gamblers. The recent Health

Professions Council's 'practitioner psychologists' guidelines (2015) emphasise how the Counselling Psychologist, in particular, must be able to 'understand the therapeutic relationship and alliance as conceptualised by each model' as well as being able to 'understand social and cultural contexts and the nature of relationships throughout the lifespan'.

The therapeutic relationship can be a tool of healing for people who have suffered primal damage in their attachment system, in this way providing a corrective experience. This can be said to be true no matter which approach is selected for working with clients, but perhaps to varying degrees with some placing more emphasis on the relational element than others. Beck et al., proposed that rapport in the therapeutic relationship consists of a combination of emotional and intellectual components in which the patient perceives the therapist as someone: a) who is tuned in to her feelings and attitudes, b) who is sympathetic, empathic and understanding, c) who is accepting of all her faults d) with whom she can communicate without having to spell out her feelings and attitudes in detail or qualify what she says (Beck et al., 1979, p. 51, cited in Milton, 2010).

Furthermore, great consideration should be given to the fact that meeting with another in a therapeutic context can pose many challenges. One prominent aspect of the women's experience emanating from their narratives was the existence of both the desire for and a fear of attachment. The women convey their deep desire to belong, to be accepted, to be loved, and to share in relatedness in its various forms, whether that be intimate or platonic relationships, being part of a family or group, or simply to share an experience. However, for some, it is their overwhelming fear of rejection that inhibits such connection and results in a prevailing sense of loneliness and isolation. As a result of this fear, narratives denote how some of the women have learned protective mechanisms to help them function in relationships. Although attachment theory is not a model of therapy itself it could be argued that using attachment theory to utilise the relational aspects of other models will strengthen therapeutic work (Woolfe et al, 2014).

Further learnings should be taken from the fact that so many participants struggled with endings. This should also be given careful and sensitive consideration within the therapeutic context, and women should be appropriately prepared for the final session.

4.5.4 The Reflexive Practitioner

The importance of cultivating practitioner self-awareness is central in Counselling Psychology. I would argue this is especially true for psychologists when working with complex, emotionally

vulnerable clients that demonstrate interpersonal difficulties. Whilst it is important to help our clients move from a pre-reflective to more reflective position to help them embrace new possibilities, this is an equally important and continuing process for us to engage with as therapists. The BPS, Division of Counselling Psychology Professional Practice Guidelines (2015) outline how practitioners must develop their self-reflective skills, and gain an understanding of their 'use of self' in their professional work. The guidelines make clear that the individual practitioner has a responsibility to develop and maintain an awareness of their self. Counselling Psychologists must seek to understand their role in the therapeutic work, and how they affect it (Blair, 2010). This is echoed by Dewane (2006) who asserts that therapists must be aware of 'who their self is' in the relational encounter.

Clear boundaries are important when working with clients who have not had boundaries set for them. Linked to this, I would like to highlight our own potential to collude with clients at times and to provide what clients may appear to want or demand, but it is sometimes important to take a step back and challenge this with them. For example, this study denotes how women tended to avoid difficult feelings, yet it may be in their best interests to tentatively explore this with them. Another pertinent theme is that of relinquished responsibility and ambivalence; it is easy to be drawn into the role of doing things on behalf of our clients, yet this is in neither our nor their interests. It may be easier to ignore this type of dynamic, especially if the client continues to attend each session each week. Yet it is crucial to explore this with them, or they risk completing treatment and relapsing. Service provisions, practicalities, time constraints, and our own anxiety may influence our decision making in such difficult circumstances, setting limitations upon what seems achievable, but developing practitioner self-awareness through reflection and communicating 'what is not being said' in the therapeutic encounter with the client may in itself be a healing experience for them. Appropriate training and excellent supervision are integral here.

4.5.5 Breaking Down the Barriers

As we have discussed there are many barriers to treatment which prevent women from accessing help that they badly need. It is therefore a recommendation for Counselling Psychologists to consider alternative means of reaching and engaging this population which take into account clients' resources, including their psychological mindedness, readiness to engage and openness to trying new things, in this way remaining person centred rather than disorder-centred. Findings of this study indicate that online therapy, helplines and forums may be beneficial for women to overcome some of the practical accessibility issues they face, such

as time, distance and cost. It is therefore suggested that Counselling Psychologists consider alternative ways of engaging and reaching women by providing or facilitating online or remote therapy, helplines or local support groups. Finding creative ways to help is part of the challenge of practice, allowing Counselling Psychologists to go beyond the mechanistic application of theory and research and to engage with uncertainty (Cooper, 2007, cited in Milton, 2010). Relatives can be a main motivating factor for women to access support, highlighting the central role of relationships for women that need help with their problems, as discussed. This may provide a clue as to how to reach women, perhaps through targeted campaigns, and it serves to illuminate the difficulties relatives may be experiencing, which could be another area for future research and support services, therefore a systemic approach and psychoeducation may be useful. Inherent within this are implications for service providers and the future development of policies and guidelines.

4.5.6 Navigating the NHS

I would like to add a final thought in this section with regards to Counselling Psychologists working within the NHS, given that this study was based in an NHS setting and also the recent drive for Counselling Psychologists to take up roles within the public health sector. It is important to recognise that the therapy arena is also contextual and it is likely that it will be impacted by and impact upon its context (Lemma, 2003). Many NHS services consist of multi-disciplinary teams in which the medical model is prevalent. Typical pressures within these services include service agreements, waiting times, administration, caseloads, outcome measures, management, and organisational politics, all of which impact on interventions. Decisions must be 'justified' to those who have more 'power'. Chwalisz (2003) describes the tension that can be inherent when working in multi-disciplinary settings, between the humanistic ethos that underlines Counselling Psychology, and the medical model, which forms the dominant paradigm in the health care system. Blair (2010) notes that the medical model espouses a rationalistic approach to scientific enquiry, whereas the humanistic view sees the importance of relationships and shared creation of meaning. I wish to leave a final thought here that despite these tensions, much can be learned from professionals working in other disciplines and a collaborative approach with team members is encouraged; most importantly, clients who present for treatment can ultimately benefit from a wider range of ways of working psychologically. Regardless of the model of choice, it is down to the individual practitioner to bring themselves to the therapeutic encounter and in this way to create a strong therapeutic rapport.

4.6 Reflections

4.6.1 Reflections on Analysis

As described in more detail in the Methodology Chapter, IPA was selected because it was deemed the most suitable approach to answer the research questions, and to generate the type of knowledge that I hoped to produce. It attempted to join a critical realist perspective with a contextual constructionist epistemology and in this way it sought to produce an account of meaning making of the subjective experiences of individuals located in a 'real' world,' acknowledging that knowledge is local, provisional and dependent and that different viewpoints can provide unique understandings of the same phenomenon. This was delineated in the women's narratives since many different viewpoints, understandings and perspectives of the phenomenon being investigated emerged. It seems important, however, that some participants appeared to find it more difficult to express emotions, thoughts, perceptions and sensations in order to communicate the texture of their experiences (Willig, 2001). In these instances I was careful to consider contextual factors, mindful not to allow my interpretations to be too clouded by my own assumptions or desire to fill in gaps in their descriptions, to maintain a balance. Throughout the analysis stage, I was vigilant to use the guidelines for the method of analysis as a guide rather than an instruction book, as suggested by Smith et al. (2009). However at times I found the 'openness' and 'flexibility' of the method to be daunting, desiring some sort of manual to add structure and certainty. Once I had overcome initial uncertainty, and having gained more confidence through discussing initial findings in supervision and with peers, I found my own rhythm and style. For example, I enjoyed the creative process of cutting out sentences on post it notes and spreading them out over the floor and organising these into themes or categories. The iterative nature of the process felt natural as I progressed through different stages of the study, constantly revisiting and revising previous chapters, thoughts and assumptions.

4.6.2 Reflections on my Influence on the Research

In this section I would like to further consider how I have been involved in shaping the findings of the research, which Willig (2001) acknowledges as imperative in qualitative research. My position as a 35 year old, white, female; a researcher, and as a trainee Counselling Psychologist on placement at the [redacted], influenced the data collection and analysis.

Furthermore my epistemological stance influenced what could be found and what I was looking for.

Despite my decision not to disclose my dual role at the [redacted] unless prompted, many participants assumed I was part of the clinic, which I believe had several effects on the results. For example, I may have been viewed as being on the 'other side' or regarded as being in a position of authority, with power dynamics feeding into the process, preventing participants from opening up fully. Some participants appeared eager to please, and there may have been some bias in their accounts if they felt inhibited or unable to criticise their treatment at the clinic. I also became increasingly mindful of my own distance from the experience of problem gambling, especially since a key theme to emerge for some participants was the importance of feeling understood through shared experience. While this sense of being removed from the experience enabled my open curiosity, it also meant I could not share this particular personal experience with my participants. While I would argue two people can never have the same experience and this should not influence my ability to empathise with or at least fully acknowledge my participants experiences, this seemed important to participants. I endeavoured to apply person-centred core conditions of congruence, unconditional positive regard and empathy (Rogers, 1995) throughout the interview process, hoping to demonstrate how valued each participant was and to meet them as fellow human beings.

Yet there was also a balance to be found in maintaining appropriate boundaries. I noticed a shift in my own perceptions of the participants and my inner-relating to them through the iterative process of analysis, with a felt sense of closeness to them. As I write my final reflections, I find myself referring to the women as 'my' participants, shifting from previously thinking of them as 'the' participants. Buber (1970) provides interesting insights that may shed light on this in his book 'I and Thou', which purports that human life finds its meaningfulness in relationships. He highlights the transient or manifold nature of living relationships, which he suggests are sustained in the spirit and mind of an "I" for as long as the feeling or idea of relationship is the dominant mode of perception.

Finally, I would like to reflect on how my own lack of experience in IPA research influenced the data I collected and my analysis. With more experience, skill (and hindsight), I may have been able to gather richer data from participants which may have influenced my overall findings. These reflections highlight the inevitability of the researcher impacting on the research process

and influencing their findings. This cannot be avoided, but is a natural part of the research journey and in this way, it should be acknowledged as an important part of the findings.

4.6.3 Reflective Statement

The beginning of this study was marked by uncertainty, anticipation, anxiety and excitement around what findings might emerge and how I would navigate the seemingly vast task of collating information, accurately representing and providing a voice for this underrepresented population of female problem gamblers; perhaps akin to the uncertainty and conflict experienced by the women themselves as they embarked upon their therapeutic journey. Unlike the women in this study however, I have been fortunate enough to have the understanding, support and guidance of my supervisor and peers to keep me on track and help me find my way through some of the murkier patches when things have felt 'out of control'.

During this process, the science-practitioner gap between researcher and therapist narrowed as I gained more insight into qualitative research and my confidence in my identity as a Counselling Psychologist emerged and developed. Despite at first wrestling with my role as 'researcher' while interviewing this vulnerable group about such a sensitive topic, I found myself growing into the role, able to sit back and just 'be with' the participants and learn from them rather than attempting to 'do' anything therapeutically.

The experience of listening to such detailed life accounts was immensely rewarding; I felt privileged that the participants placed their trust in me, allowing me to glimpse their inner worlds including their perceived failings, foibles and fears. It has been enlightening and humbling to discover client perspectives in their raw form, shining light on not only the positive aspects of therapy, but the finer nuances and negative aspects of their experiences which are coloured by their world of objects, relationships, language, culture, projects and concerns. It highlighted for me how rarely I find the opportunity to sit and reflect on clinical practice in this way, or to gain such detailed and honest feedback to inform practice, but also the importance of making space for this reflective process and just how much can emerge from it.

Throughout the research process, my hermeneutic reflection evolved and developed. As I read and re-read the transcripts and chapters of the thesis, digesting and processing participants' narratives, new ideas and awareness continued to emerge. Through this intense, iterative process, treatment recommendations and ideas emerged. I listened to what the participants' words really meant, attempted to engage in what was also not being said, putting myself in their shoes as I tried to feel what they felt. This meant entering their worlds of shame, fear and

helplessness; an exhausting, heavy, but enriching endeavour, which opened my eyes to the strength and will to survive demonstrated by these women, even in the face of rejection and the depths of despair. Going beyond the surface in this way and developing a more interpretive stance has also influenced my clinical work as well as my views and observations outside of a 'professional' capacity'. It has awakened and stimulated my awareness of just how much of any conversation gets lost in translation and goes unheard.

I have been struck by my enjoyment of the qualitative research process, and in particular I have felt immersed in the topic of problem gambling and hope to further pursue it in terms of research and clinical practice. I have been fortunate enough to meet and discuss pertinent issues with fellow professionals with an interest within the field and I feel as though I myself have found a new group in which to belong, where I have enjoyed sharing thoughts and findings.

Looking back on the journey of writing the thesis however I feel a sense of ambivalence, perhaps similar to the participants about what this has meant to me. While I feel proud to have been able to achieve something personally and professionally, the process of writing revealed how much I still struggle to stay with my own uncomfortable feelings and uncertainty, with a tendency to cut off from these and move on to another distraction. This is something I must remain mindful of during sessions with clients where it is much easier to move away from the difficult feelings of my clients or of myself in order to make a session feel more comfortable. On a personal note, findings have made me reflect on my grandfather's experience of gambling socially, and I wonder about the extent to which this may have been an escape for him, as a holocaust survivor who lost so many of his family members including his parents and siblings. Perhaps at times, he himself needed to find a distraction from painful memories.

As this part of my journey comes to an end, a new one begins as I am now eight months pregnant with my first baby and a renewed sense of uncertainty, anticipation, anxiety and excitement is present. Meeting other new mums-to-be at an antenatal group provides an opportunity to learn and share experiences, relieving anxiety for example by having a giggle about the shared experience of not being able to easily put on my own socks! This serves as yet another reminder of the power of feeling heard, understood and accepted. I hope this research provided a platform for my participants to be heard and that they feel they have benefitted from participating in this research; I will always hold each of the eight women in mind, and hope that they find what they are searching for and that this may help alleviate their desire to gamble.

4.7 Conclusions

The field of problem gambling is a complex area where further research is needed to establish whether there is a more effective way to help and treat women with problems in this area. At first glance female problem gamblers may appear to be a unified group, but as my research highlights, they are in fact a group of unique individuals sharing the human condition and basic need to feel understood, accepted and to connect with others. Underneath the 'problem gambler' lies a place of vulnerability, helplessness and shame which needs to be acknowledged and accepted. There is hope that this can be achieved through research-based, individualised, therapeutic interventions. This research has highlighted the central role that the therapeutic relationship must play in helping to create a restorative relational experience in which trust lies at the core. If this can be achieved, it is argued therapy may be instrumental in breaking down the barriers to help these women engage in treatment at a time when gambling is increasingly available and actively promoted to women.

References

Aasvad, M. (2002). *The psychodynamics and psychology of gambling*, Springfield, Charles C Thomas

Abbott, M., Volberg, R., Bellringer, M., & Reith, G. (2004). *A Review of Research on Aspects of Problem Gambling*. Auckland University of Technology, Gambling Research Centre: London: Responsibility in Gambling Trust.

Advertising Standards Agency. (2014). Public perceptions of gambling advertising in the UK, Qualitative research. Retrieved on January 26th 2015 from https://www.asa.org.uk/News-resources/~/media/Files/ASA/Reports/ASA%20Gambling%20Advertising%20Research%20Agency%20Report.ashx

Alvesson, M, & Skoldberg, K. (2009). *Reflexive Methodology, New Vistas for Qualitative Research*. second edition, London, Sage.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Washington DC: American Psychiatric Association.

Archer, D. (2014). Freebets downloaded on August 4th 2015 at: https://www.freebets.com/news/16313/asa-produces-misleading-report-on-gambling-advertising

Avery, L., & Davis, D. R. (2008). Women's recovery from compulsive gambling: Formal and informal supports. *Journal of Social Work Practice in the Addictions*, 8, 171–191.

Banister, P., Burman, E., Parker, I., Taylor, M, &Tindall C, (1994). *Qualitative Methods in Psychology: A Research Guide,* England, Open University Press.

Bandura, A. (1971). *Social Learning Theory*, General Learning Press

Barker, C., Pistrang, N, & Elliot, R. (2002). *Research Methods in Clinical Psychology*. Chichester: Wiley.

Bateman A, & Fonagy, P. (2006). *Mentalization based treatment: a practical guide*. Oxford: Oxford University Press; 2006.

Beidel, D & Turner, S (1986) A critique of the theoretical bases of cognitive behavioral theories and therapy, Clinical Psychology Review, 1986, Volume 6, Issue 2

Bellringer, M., Pulford, J., Abbott, M., DeSouza, R., & Clarke, D. (2008). Problem gambling-barriers to help-seeking behaviours. Auckland. Retrieved on January 26th from: http://aut.researchgateway.ac.nz/bitstream/handle/10292/2014/Report%20final%2010%20September%202008.pdf?seq

Bhaskar, R. (1978). *A realist theory of science*. Atlantic Highlands, NJ: Humanities Press.

Boyd, W, & Bolen, D. (1970). The compulsive gambler and spouse in group psychotherapy. *International Journal of Group Psychotherapy* 20(1), 77 – 90

Blair, L. (2010). A critical review of the scientist-practitioner model of counselling psychology. *Counselling Psychology Review*, 25(4), 19-30.

Blanco, C., Hasin, D. S., Petry, N., Stinson, F. S., & Grant, B. F. (2006). Sex differences in subclinical and DSM-IV pathological gambling: Results from the National Epidemiologic Survey of Alcohol and Related Conditions. *Psychological Medicine,* 36, 943–953.

Blaszczynski, A., & Nower, L. (2002). A pathways model of problem and pathological gambling, *Addiction*, 97, 487–499.

Buber, M. (1970). *I and Thou*, New York, Scribners

Blumer, H. (1969). *Symbolic interactionism*. Englewood Cliffs, NJ: Prentice Hall.

Blum, H.P. (2003). Psychic Trauma and traumatic object loss, *Journal of the American Psychoanalytic Association*, 51: 415 - 431

Bor, R., Watts, M. (2011). *The Trainee Handbook, A Guide from Counselling Pschotherapy Trainees*, 3rd edition: London, Sage.

Bowlby, J. (1979). The Making and Breaking of Affectional Bonds. London: Tavistock

Bowlby, J. (1988). A Secure Base: Parent-Child Attachment and Healthy Development. New York, Basic Books

Boucher, T. (2010). Cognitive-behavioural Contributions to Pluralistic Practice: Reflections on an issue of some contention. In Milton, M. *Therapy and Beyond*. (pp. 155 – 169) Chichester, Wiley-Blackwell

Boucher, T. (2006). In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship? *Counselling Psychology* review, 21 (3): 12 - 18

Breakwell, G., Smith, J.A, & Wright, D.B. (2012). *Research Methods in Psychology* (4th edition). London: Sage.

British Psychological Society, (2014). *Code of ethics and conduct*. Leicester: The British Psychological Society.

British Psychological Society, (2014). *Code of Human Research Ethics*. Leicester. The British Psychological Society.

British Psychological Society, Division of Counselling Psychology. (2015). Practice Guidelines, Retrieved on June 27th 2015 from: http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-_division_of_counselling_psychology.pdf

Brown, S., & Coventry, L. (1997). Queen of hearts: The needs of women with gambling problems. Melbourne: Financial and Consumer Rights Council.

Bryman, A, & Cramer, D. (2004). *Quantitative Data Analysis with SPSS*. London: Routledge. ISBN: 0415340802.

Buchner, U., Erbas, B., Sturmer, M., Arnold, M., Wodarz, & Wolstein., J. (2015). Inpatient Treatment for Pathological Gamblers in Germany: Setting, Utilization, and Structure, *Journal of Gambling Studies*, 31: 257-279.

Bunge, M. (1993) Realism and antirealism in the social science. *Theory and Decision*, 35, 207 – 235.

Burglass, M. E., & Shaffer, H. (1984). Diagnosis in the addictions I: Conceptual problems. Advances in Alcohol and Substance Abuse, 3, 19–34

Burns, R.B. (2000). *Introduction to Research Methods* (4th ed.). London: Sage.

Burr, V. (2003). *Social Constructionism*. 2nd ed. Hove, E Sussex: Routledge.

Carroll, A., Davidson, T., Marsh, D & Rodgers, B. (2011) Help-seeking and Uptake of Services Amongst People with Gambling Problems in the ACT. Gambling and Racing Commission.

Castellani, B. (2000). *Pathological gambling. The making of a medical problem*, New York: State University of New York Press.

Charmaz, K. (2003). Grounded theory. In J.A. Smith (Ed.), Qualitative psychology: A practical guide to research methods. (1st ed., pp.81-110). London: Sage.

Chen, P., Jindani, F., Perry, J, & Turner, N. (2014). Mindfulness and problem gambling treatment, *Asian Journal of Gambling Issues and Public Health*. 2014,4:2 retrieved on August 2nd from http://www.ajgiph.com/content/4/1/2

Chwalisz, K. (2003). Evidence-Based Practice: A Framework for Twenty-First-Century Scientist-Practitioner Training; *The Counseling Psychologist* September 2003 vol. 31 no. 5 497-528

Clotfelter, C. & P. Cook. 1993. The gambler's fallacy in lottery play. Manage. Sci. 39: 1521–1525.

Collins English Dictionary (2003), 6th Ed. Glasgow: Harper Collins Publishers

Cooper, M, & McLeod, J. (2007) A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research*, 7(3): 135 - 143

Crisp, B. R., Thomas, S. A., Jackson, A. C., Smith, S., Borrell, J., Ho, W., Holt, T. A., & Thomason, N. (2004). Not the same: A comparison of female and male clients seeking treatment from problem gambling counselling services. *Journal of Gambling Studies*, 20, 283–299.

Crisp, B. R., Thomas, S. A., Jackson, A. C., Thomason, N., Smith, S., Borrell, J., Ho, W, & Holt, T. A. (2000). Sex differences in the treatment needs and outcomes of problem gamblers. *Research on Social Work Practice*, 10, 229–242.

Cunningham, J. A. (2005). Little use of treatment among problem gamblers. Psychiatric Services, 56, 1024– 1025.

de Lisle, SM., Dowling, NA, & Allen, JS. (2011). Mindfulness-based cognitive therapy for problem gambling. Clinical Case Studies, 10, 210–228.

de Lisle, SM, Dowling, NA, & Allen, JS. (2012). Mindfulness and problem gambling: a review of the literature. *Journal of Gambling Studies*, doi:10.1007/s10899-011-9284-7

Department of Health, (2004). Agenda for Change, retrieved October 26, 2014 from http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/en/managingyourorganisation/workforce/paypensionsandbenefits/agendaforchange/index.htm

Dewane, C. (2006). Use of self: a primer revisited *Clinical Social Work* Journal, Vol. 34, No. 4, p. 543 - 558

Donnely, C., (2009). Gambling as a means of relieving distress: understanding the connections among interpersonal trauma, perceived social support and unsupport, and problem gambling, Carleton University, retrieved in July 2015 from: https://curve.carleton.ca/system/files/theses/28265.pdf

Dowling, N., Smith, D., & Thomas, T. (2005). Electronic gaming machines: are they the 'crack-cocaine' of gambling. *Addiction*,100,33–45.

Dowling, N., Smith, D, & Thomas, T. (2006a). Treatment of female pathological gambling: Efficacy of a cognitive-behavioural approach. *Journal of Gambling Studies*, 22,355–372.

Dowling, N., Smith, D., & Thomas, T. (2006b). A comparison of individual and group cognitive-behavioral treatment for female pathological gambling. *Behaviour Research and Therapy*, 45, 2192–2202.

Dowling, N. & Cosic., S. (2011). Client Engagement Characteristics Associated with Problem Gambling Treatment Outcomes, International Journal of Mental Health Addiction, 9:656 - 671

Dwyer, S., Piquette, N., Buckle, J, & McCaslin., E. (2013). Women gamblers write a voice: Exploring journaling as an effective counseling and research tool. *Journal of Groups in Addiction & Recovery*, 8(1), 36.

Eatough, V, & Smith, J. A. (2008). Interpretative phenomenological analysis, in C. Willig and W. Stainton Rogers (eds) The Sage Handbook of Qualitative Research in Psychology. (pp.179 – 194) London: Sage.

Eatough, V. & Smith, J.A. (2006). I feel like a scrambled egg in my head: An idiographic case study of meaning making and anger using interpretative phenomenological analysis, *Psychology and Psychotherapy: Theory, Research and Practice Volume* 79, Issue 1, 115–135

Echeburua, E., Gonzalez-Orgega, I., de Corral, P., & Polo-Lopez, R. (2011). Clinical gender differences among adult pathological gamblers seeking treatment. *Journal of Gambling Studies*, 27, 215–227.

Evans, L, & Delfabbro, P. (2005) Motivators for change and barriers for seeking help among Australian problem gamblers. Journal of Gambling Studies, 21, 133-155

Finlay, L. (2002a) "Outing" the Researcher: The Provenance, Process and Practice of Reflexivity, *Qualitative Health Psychology*, 12, 531 – 545.

Finlay, L. (2002b) Negotiating the Swamp: the Opportunity and Challenge of Reflexivity in Research Practice. *Qualitative Research*, 2, 209 – 230.

Fonagy, P., Gergely, G., Jurist., E, & Target, M. (2004). *Affect regulation, mentalization and the development of the self*. London, Karnac.

Flores, P. (2006). Conflict and Repair in Addiction Treatment: An Attachment Disorder Perspective, Journal of Groups in Addiction & Recovery, Volume 1, Issue 1

Flores, P. (2011). Addiction as an attachment disorder, A Jason Aronson Book

Gainsbury, S., Hing, N, & Suhonen. N. (2014). Professional help-seeking for gambling problems: awareness, barriers and motivators for treatment, *Journal of Gambling studies*, 30: 503 – 519

Gavriel-Fried, B., & Ajzenstadt, M. (2012). Pathological women gamblers: Gender-related aspects of control. *Sex Roles*, 66(1-2), 128-142.

Geiger, P., Peters, Jl Sauer-Zavala, S., & Baer, R. (2013). Relationships among maladaptive cognitive content, dysfunctional cognitive processes and borderline personality features; Journal of personality disorders, 27(4) pp.457 – 464, The Guilford Press

Giorgi, A. (1985). The Phenomenological Psychology of Learning and the verbal learning tradition, in A. Giorgi (ed) Phenomenology and psychological research. Pittsburgh, PA. Duquesne University Press.

Giorgi, A. (1994). A Phenomenological Perspective on Certain Qualitative Research Methods. Journal of Phenomenological Psychology, 25, 190 – 220.

Giorgi, A. P. & Giorgi, B. (2013). Phenomenological psychology, in C. Willig and W. Stainton Rogers (eds) *The Sage Handbook of Qualitative Research in Psychology*. London: Sage. Chapter 10, p. 165.

Grant JE, Kim SW. (2002).Gender differences in pathological gamblers seeking medication treatment. Compr Psychiatry 43:56-62.

Grant JE, Kim SW, Kuskowski M. (2004). Retrospective review of treatment retention in pathological gambling. Compr Psychiatry 45:83-87

Grant, J.E., Chamberlain, S., Schreiber, L, & Odlaug, B. (2012). Gender-Related Clinical and Neurocognitive Differences in Individuals Seeking Treatment for Pathological Gambling, Journal of Psychiatric Res; 46(9): 1206-1211

Griffiths, M.D. (2001). Internet gambling: Preliminary results of the first UK prevalence study, Journal of Gambling Issues, 5.

Griffiths, M. D. (1996). Pathological gambling: A review of the literature. Journal of Psychiatric and Mental Health Nursing, 3, 347–353

Griffiths, M. D, & MacDonald, H. F. (1999). Counselling in the treatment of pathological gambling: An overview. British Journal of Guidance and Counselling, 27, 179–190

Griffiths, M.D. (2004). Betting your life on it: Problem gambling has clear health related consequences. Br Med J, 329, 1055 – 1056

Griffiths, M. D. (2005). A “components” model of addiction within a biopsychosocial framework. Journal of Substance Use, 10, 191–197.

Griffiths, M. D., & Larkin, M. (2004). Conceptualising addiction: The case for a 'complex systems' account. Addictions Research and Theory, 12, 99–102.

Halliwell, E., Main., L, & Richardson, C., (2007). The fundamental facts, latest facts and figures on mental health, Mental Health Foundation, retrieved from

http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental_facts_2007.pdf?view=Standard

Harper, D & Thompson, A. (2012). *Qualitative Research Methods in Mental Health and Psychotherapy*: Wiley Blackwell.

Haseltine, F. P. (2000). Gender differences in addiction and recovery, *Journal of women's health and gender-based medicine*, volume 9, number 6 p.576 – 583

Health & Care Professions Council. (2015). Standards of proficiency, Practitioner Psychologists, retrieved on July 20th 2015 from http://www.hpc-uk.org/assets/documents/10002963sop_practitioner_psychologists.pdf

Heidegger, M. (1962). *Being and Time*. Oxford, Blackwell.

Heron, J. (1996). *Co-operative Inquiry: Research into the human condition*. London: Sage.

Hing, N., & Breen, H. (2001). 'Profiling lady luck: an empirical study of gambling and problem gambling amongst female club members', *Journal of Gambling Studies*, vol. 17, no. 1, pp. 47-69.

Hodgins, D., Currie, S., el-Guebaly, N., Peden, S. (2004). Brief Motivational Treatment for Problem Gambling: A 24-Month Follow-Up. *Psychology of Addictive Behaviors,* Vol. 18, No. 3, 293–296

Holdsworth, L., Hing, N., & Breen, H. (2012). Exploring women's problem gambling: a review of the literature, *International Gambling Studies* Vol. 12, No. 2, August 2012, 199–213

Holmes, J. (1993). *John Bowlby and attachment theory*, Routledge

Hraba,J.,& Lee, G. (1996).Gender, gambling and problem gambling. *Journal of Gambling Studies*, 12, 83–101.

Husserl, E. (1931). Ideas: A General Introduction to Pure Phenomenology (WR. Boyce Gibson, Trans.). London. UK: Allen & Unwin (Original work published 1913).

Husserl, E. (1982). Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: First book. General introduction to pure phenomenology (F. Kersten) London UK: Kluwer (Original work published 1913).

Ibanez, A., Blanco, C., Moreryra, P., & S´aiz-Ruiz, J. (2003). Gender differences in pathological gambling. *Journal of Clinical Psychiatry*, 64, 295–301.

Jacobs, D. (1986). A general theory of addictions: a new theoretical model. *Journal of gambling behaviour*, Volume 2, Issue 1, pp 15-31

Jarvis, P. (1999). The Practitioner Researcher. San Francisco, Jossey-Bass.

Karter, L. (2013). *Women and Problem Gambling: therapeutic insights into understanding addiction and treatment*. London: Routledge.

Karter, L. (2015). *Working with Women's Groups for Problem Gambling*, London: Routledge

Kasket, E, & Gil-Rodriguez, E. (2011). The Identity Crisis in Trainee Counselling Psychology Research, Counselling Psychology Review, Vol 26, No.4, BPS.

Kasket, E. (2012). The Counselling Psychology Researcher, Dialogues & Debates; Counselling Psychology Review. Vol 27, No.2, June 2012, BPS.

Kasket, E. (2012). The Counselling Psychologist Researcher, Counselling Psychology review, vol 27 n.2

Kim, Y. (2010) The Pilot Study in Qualitative Inquiry: Identifying Issues and Learning Lessons for Culturally Competent Research, Qualitative Social Work July 1, 2015 14: 572-588

Kirk, J, & Miller, M. (1986). *Reliability and validity in qualitative research*: Sage.

Korn, D. A., & Shaffer, H. J. (1999). Gambling and the health of the public: Adopting a public health perspective. Journal of Gambling Studies, 15(4): 289-365.

Krefting, L. (1991) Rigor in Qualitative Research: The Assessment of Trustworthiness, *The American Journal of Occupational Therapy*, Volume 45, Number 3, 214 – 222.

Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing*, Sage.

Ladouceur, R., Sylvain, C., Bouting, C., Lachance, S., Doucet, C., Leblond, J, & Jacques, C. (2001). Cognitive Treatment of Pathological Gambling, *Journal of Nervous Mental Disease*, Vol 189: p 774 –780

Ladouceur R, Lachance S, Fournier PM. (2009). Is control a viable goal in the treatment of pathological gambling? *Behav Res Ther* 47: 189-197.

Langer, E.J. (1975). The illusion of control. J. Pers. Soc. Psychol. 32: 311–328.

LaPlante, D. A., Nelson, S. E., LaBrie, R. A, & Shaffer, H. J. (2011). Disordered gambling, type of gambling and gambling involvement in the British Gambling Prevalence Survey 2007. *European Journal of Public Health*, 21(4), 532-537

Ladd, G. T., & Petry, N. M. (2002). Gender differences among pathological gamblers seeking treatment. Experimental and Clinical Psychopharmacology, 10, 302–309.

Larkin, M., Watts, S, & Clifton, E. (2006). Giving voice and making sense in interpretive phenomenological analysis. *Qualitative Research in Psychology*, 3, 201 – 120.

Landridge, D. (2004). Research Methods and Data Analysis in Psychology. Harlow, UK: Pearson Education Ltd.

Landridge, D. (2007). *Phenomenological Psychology: Theory, research and method.* Harlow, UK: Pearson Education Ltd.

Ledgerwood, D., Wiedemann, A., Moore, J., Arfken, C. (2012). Clinical characteristics and treatment readiness of male and female problem gamblers calling a state gambling helpline. Addiction Research & Theory, Apr 01, 2012; Vol. 20, No. 2, p. 162-171

Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic Psychotherapy*, Chichester, Wiley

Lesieur, H., & Rosenthal, R. (1991). Pathological gambling: a review of the literature (prepared for APA task force of DSM-IV committee on disorders of impulse control not everywhere classified) Journal of gambling studies, Volume 7, Issue 1, pp 5-39

Linnet, J, & Pedersen, A. (2014). Waiting Time Increases Risk of Attrition in Gambling Disorder Treatment, *Journal of Addiction Prevention*. Vol.:2, Issue:2

Linder, R., (1950) The psychodynamics of gambling. American Academy of Political and Social Science, Vol. 269, Gambling. pp 93 – 107

Lincoln, Y.S. & Guba, E. A. (1985). *Naturalistic Inquiry*, Beverly Hills, Sage.

Lyons, E & Coyle, A. (2007). *Analysing Qualitative Data in Psychology*, London, Sage.

Martins, S., Storr, C., Ialongo, N, & Chilcoat, H. (2008). Gender differences in mental health characteristics and gambling among African-American adolescent gamblers, *The American Journal on Addictions*. 17: 126 – 134,

McMillen, J., Marshall, D., Murphy, L., Lorenzen, S, & Waugh, B. (2004). Help-seeking by problem gamblers, friends and families: A focus on gender and cultural groups. Acton, ACT, Australia: ACT Gambling and Racing Commission. Retrieved from: https://digitalcollections.anu.edu.au/bitstream/1885/45186/3/Help-seeking-FINAL-revised.pdf

McCormack, A., Shorter, G., Griffiths, M.D. (2014). An empirical study of gender differences in online gambling. *Journal of Gambling Studies*, Volume 30, Issue 1, pp 71-88

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20.

Marshall, C. & Rossman, G. (1989). *Designing Qualitative Research*, 2nd edition. Newbury Park, Sage.

McLeod, J. (2000). *Qualitative Research in Counselling and Psychotherapy*. London: Sage. . London: Sage.

McLeod, J. (2003) *Doing Counselling Research*, London, Sage

Miles, M.B, & Huberman, M. (1994). *Qualitative Data Analysis*. New York: Sage.

Millner, M, & Rollnick, S. (2013). *Motivational Interviewing: Helping people change*. (3rd ed) New York, London, The Guildford Press

Milton, M. (2006) 'Reflections on the past: Thoughts about the future...' *Counselling Psychology Review*, 21 (1), 8-10. Blackwell.

Milton, M. (2010). *Therapy and Beyond, Counselling Psychology Contributions to Therapeutic and Social Issues*: Chichester, Wiley-Blackwell.

Mearns, D, & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy*, London, Sage

Merleau-Ponty, M. (1962) *Phenomenology of Perception* (C.Smith, Trans). London: Routledge & Kegan Paul.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology*, 11, 799-808.

Moran, D. (2000). *Introduction to phenomenology*, London, Routledge.

Morrow, S. (2005). Quality and Trustworthiness in Qualitative Research in Counselling Psychology*, Journal of Counselling Psychology*, Vol, 52, No 2, 250 – 260.

National Gambling Impact Study Commission, (1999) Final report, Washington, DC: US. Government Printing Office. Retrieved from:

http://www.gpo.gov/fdsys/pkg/CHRG-106shrg57795/pdf/CHRG-106shrg57795.pdf

National Problem Gambling Clinic, (2013). Unpublished dataset retrieved from NPGC database

Nightingale, D, & Cromby, J. (1999). Social Constructionist Psychology, Buckingham: Open University Press.

Nixon, G., Evans, K., Grant Kalischuk, R., Solowoniuk, J., McCallum, K, & Hagen, B., (2012). Female gambling, trauma, and the not good enough self: an interpretative phenomenological analysis*, International Journal of Mental Health Addiction*, Springer

O'Brien, C. (2011). Depression, cause or consequence of pathological gambling and its implications for treatment, *Counselling Psychology Review*, Vol 26, No.1, BPS

Odlaug, B., Schreiber, L, & Grant, J. (2012). Personality Disorders and Dimensions in Pathological Gambling. Journal of Personality Disorders: Vol. 26, No. 3, pp. 381-392. doi: 10.1521/pedi.2012.26.3.381

Ofcom, (2013). Trends in Advertising Activity. Retrieved from: http://stakeholders.ofcom.org.uk/binaries/research/tv-research/Trends_in_Ad_Activity_Gambling.pdf

Osborn, M., & Smith, J.A. (1998). The Personal Experience of Chronic Benign Lower Back Pain: An Interpretive Phenomenological Analysis. *British Journal of Health Psychology*, 2, 65 – 83.

Palmer, RE. (1969). *Hermeneutics,* Northwestern University Press.

Parke, A., & Griffiths, M. (2012). Beyond illusion of control: An interpretative phenomenological analysis of gambling in the context of information technology. *Addiction research & theory* (1606-6359), 20 (3), p. 250.

Peele, S. (1990). Addiction as a cultural concept. Annals of the New York Academy of Sciences, 602, 205–220.

Perkins, E Benson. (1950). *Gambling in English Life*, Epworth Press, 1962. Revised edition.

Phillips, D., & Smith, W.W.M. (1997). Elevated suicide levels associated with legalized gambling. Suicide & life-threatening behavior, Volume 27, Issue 4, 373 – 378

Pidgeon, N., & Henwood, K. (1993). *Qualitative Research and Psychological Theorizing*. London: Sage.

Pidgeon, N., & Henwood, K. (1997). Using Grounded Theory in Psychological Research. In Hayes (Ed.) *Doing qualitative psychology in psychology* (pp. 245 – 273). Hove: Psychology press.

Piquette, N, & Norman, N. (2013). An all-female problem-gambling counseling treatment: Perceptions of effecti veness. *Journal of Groups in Addiction & Recovery*, 8(1), 51.

Ponterotto, J. (2005) Qualitative Research in Counselling Psychology: A Primer on Research Paradigms and Philosophy of Science. Journal of Counseling Psychology, Vol 52, No 2, 126 – 136.

Potenza, M. N., Steinberg, M. A., McLaughlin, S. D., Wu, R., Rounsaville, B. J, & O'Malley, S. S. (2001). Gender-related differences in the characteristics of problem gamblers using a gambling helpline. American Journal of Psychiatry, 158, 1500–1505.

Productivity Commission (The). (2010). Retrieved on January 26th 2015 from http://www.pc.gov.au/inquiries/completed/gambling-2009/report

Rafalin, D. (2010). Counselling Psychology and Research: Revisiting the Relationship in light of our Mission. In Milton, M. Therapy and Beyond. (pp. 44 – 55) Chichester, Wiley-Blackwell

Raylu, N., & Oei, T. (2004). Role of culture in gambling and problem gambling. *Clinical Psychology Review*, Volume 23, Issue 8, January 2004, Pages 1087–1114

Reading, B. (2002) The Application of Bowlby's attachment theory to the psychotherapy of addictions. In Weegmann, M & Cohen, R. (Eds.), *The Psychodynamics of Addiction*, (13 - 30). London & Philadelphia, Whurr Publishers

Reber, A, Reber, E & Allen, R (2009) The Penguin Dictionary of Psychology, (4th edition), Penguin Reference Library

Reid, K., Flowers, P, & Larkin, M. (2005). Exploring lived experience, *The Psychologist*, 18, 20-23.

Responsible Gambling Strategy Board (2012) Strategy. Birmingham: Responsible Gambling Strategy Board. Retrieved on January 26th 2015 from: http://www.rgsb.org.uk/publications.html.

Ricoeur, P. (1970). *Interpretation Theory: Discourse and the Surplus of Meaning*: Fort Worth: Texas Christian University Press.

Ricoeur, P. (1976) *Freud and Philosophy: an essay on interpretation*. New Haven: Yale University Press.

Ricketts, T., & Macastill, A. (2003). Gambling as an emotion management: Development of a grounded theory of problem gambling. Addiction, Research & Theory, 11, 383 – 400.

Riley, B. (2012). Experiential avoidance mediates the association between thought suppression and mindfulness with problem gambling. *Journal of Gambling Studies,* doi:10.1007/s10899-012-9342-9.

Rigbye, J, & Griffiths, M. (2011). Problem gambling treatment within the British National Health System. *International Journal of Mental Health Addiction* 9:276 – 281

Rodda, S., Hing, N, & Lubman, D. (2014). Improved Outcomes following contact with a gambling helpline: the impact of gender on barriers and facilitators, International Gambling Studies DOI: 10.1080/14459795.2014.921721

Rodda, S., & Lubman, D. (2013). Characteristics of gamblers using a national online counselling service for problem gambling, *Journal of Gambling Studies* 30:277-289

Rodda, S., Lubman, D., Dowling, N, & Jackson, A. (2013). Web-Based Counseling for Problem Gambling: Exploring Motivations and Recommendations, *Journal of Medical Internet Research, Published online 2013 May 24. doi: 10.2196/jmir.2474*

Rogers, C. (1995). *On Becoming a Person, A Therapists View of Psychotherapy*. New York, Houghton Mifflin Company

Rosenthal, R. (1987). The psychodynamics of pathological gambling: A review of the literature. In Galski, Thomas, et al. (Eds.). The Handbook of Pathological Gambling (pp. 41-70). Springfield, IL: Charles C Thomas.

Sanders, J. (2012). Use of mutual support to counteract the effects of socially constructed stigma: Gender and drug addiction Journal of Groups in Addiction & Recovery, Vol. 7, No. 2-4, p. 237-252

Schlore, A. (2001). 'The effects of a secure attachment relationship on right brain development, affect regulation and infant mental health,' *Infant Journal of Mental Health*, 22: 7 - 66

Schober, R., & Annis, H. (1996) Barriers to help-seeking for change in drinking: A gender-focused review of the literature. *Addictive Behaviours*, Vol 21. No 1, pp. 81 – 92.

Shaffer, H. J., & Korn, D. A. (2002). Gambling and related mental disorders: A public health analysis. Annual Review of Public Health, 23, 171-212

Shaffer, H. J., & Martin, R. J. (2011). Disordered gambling: Etiology, trajectory and clinical considerations. Annual Review of Clinical Psychology, 7, 483-510.

Sharpe, L. & Tarrier, N. (1993). Towards a cognitive-behavioural theory of problem gambling. British Journal of Psychiatry, 162, 407-412

Shonin, E., Van Gordon, W, & Griffiths, MD. (2013). Buddhist philosophy for the treatment of problem gambling. *Journal of Behavioral Addictions*, doi:10.1556/JBA.2.2013.001.

Shaw, R. L. (2001). Why use interpretative phenomenological analysis in Health Psychology? *Health Psychology Update*, 10, 48-52.

Silverman, D. (2000). *Doing Qualitative Research: A Practical Handbook*. London, Sage.

Silverman, D. (2001). *Interpreting Qualitative Data: Methods for Analyzing Talk, Text and Interaction*. London: Sage.

Simos, B. G. (1979). *A time to grieve*. New York: Family Service Association

Smith, J.A. (1995). Semi structured interviewing & qualitative analysis. In: Smith, J.A., Harre, R. & Van Langenhove, L. (eds) Rethinking Methods in Psychology. London: Sage. An introduction to the thematic approach of the author's interpretative phenomenological analysis.

Smith, J.A. (1996). Beyond the Divide Between Cognition and Discourse, Using Interpretative Phenomenological Analysis in Health Psychology. *Psychology and Health*, 11(2), 261 – 271.

Smith, J.A. (2004). Reflecting on the development of Interpretive Phenomenological Analysis and its Contribution to Qualitative Psychology. *Qualitative Research Psychology*, 1, 39 – 54.

Smith, J.A. (2007). Hermeneutics, human Sciences and Health: Linking theory and Practice. *International Journal of Qualitative Studies on Health and Well-being*, 2, 2-11.

Smith, J.A. (Ed.). (2008). *Qualitative Psychology: A Practical Guide to Research Methods* (2nd edition). London: Sage.

Smith, J.A, & Dunworth, F. (2003). Qualitative methods in the study of development. In: K. Connolly and J. Valsiner (eds*) The Handbook of Developmental Psychology*. London: Sage.

Smith, J.A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory Method and Research. London: Sage.

Smith, J.A., Jarman, M. and Osborn, M. (1999). Doing Interpretative phenomenological analysis. In: M. Murray and K. Chamberlain (eds) *Qualitative Health Psychology: Theories and Methods*. London: Sage.

Smith, J.A, & Osborn, M (2003). Interpretative phenomenological analysis. In JA Smith (ed) Qualitative Psychology: A Practical Guide to Methods. London: Sage.

Smith, JA, & Osborn, M. (2004). Interpretative phenomenological analysis. In G. Breakwell (ed) Doing Social Psychology. Oxford: Blackwell. (pp 229-254).

Smith, J.A, & Osborn, M. (2008). Interpretitave Phenomenological Analysis. In J.A Smith (Ed), *Qualitative psychology*: A practical guide to research methods (2nd edition. London, Sage.

Smith, S., Thomas, S., Jackson, A. (2004). An exploration of the therapeutic relationship and counselling outcomes in a problem gambling counselling service, *Journal of social work practice* Vol 18, No 1, March 2004, pp 99 – 112

Sussman, S., Nadra, L., Griffiths, M, D. (2011). Prevalence of the Addictions: A Problem of the Majority or the Minority? Evaluation & the Health Professions, 03/2011, Volume 34, Issue 1

Suurvali, H; Cordingley, J; Hodgins, D.;Cunningham, J. (2009). Barriers to Seeking Help for Gambling Problems: A Review of the Empirical Literature. *Journal of Gambling Studies*, Sep 01, 2009; Vol. 25, No. 3, p. 407-424

Suurvali, H., Hodgins, D., Toneatto, T., & Cunningham, J. (2008). Treatment seeking among Ontario problem gamblers: Results of a population survey. Psychiatric services, 59, 1343 - 1346

Svensson, J., Romild, J., Nordenmark, M., Månsdotter, A. (2011). Gendered gambling domains and changes in Sweden. International Gambling Studies, 11(2): 193-211.

Thomas, A., Allen, F., Phillips, J. (2009a). Electronic Gaming Machine Gambling: Measuring Motivation*, Journal of Gambling Studies*, Volume 25, Issue 3, pp 343-355

Thomas, A., Sullivan, G, & Allen, F. (2009b) A Theoretical Model of EGM Problem Gambling: More than a Cognitive Escape, *International Journal of Mental Health Addiction* (2009) 7:97–107 DOI 10.1007/s11469-008-9152-6

Vassilev, I, & Pilgrim, D. (2007). Risk. Trust and the myth of mental health services, *Journal of Mental Health*, 16 (3): 347 - 357

Volberg, R.A. (2003). Has There Been a 'Feminization' of Gambling and Problem Gambling in America? Electronic Journal of Gambling Issues 8: doi: 10.4309/jgi.2003.8.7 Retrieved from http://jgi.camh.net/doi/full/10.4309/jgi.2003.8.7

Wardle, H., (2015). Female gambling behaviour: a case study of realist description. PhD thesis, University of Glasgow. Retrieved July 2nd 2015 from: http://theses.gla.ac.uk/6117/

Wardle, H., Moody, A., Spence, S., Orford, J., Volberg, R., Jotangia, D., Griffiths, M., Hussey, D., & Dobbie, F. (2011a). British Gambling Prevalence Survey. National Centre for Social Research: Retrieved on January 26th 2015 from http://www.gamblingcommission.gov.uk/PDF/British%20Gambling%20Prevalence%20Survey%202010.pdf

Wardle, H., Griffiths, M.D., Orford, J., Moody, A., Volberg, R. (2011b). Gambling in Britain: a time of change? *International Journal of Mental Health and Addiction*, 10:273–277

Wardle, H., Seabury, C., (2013). 'Gambling behaviour' in Craig, R., Mindell, J. (eds) Health Survey for England 2012. Leeds: Information Centre for Health and Social Care. Retrieved from: http://www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch7-Gambling-behaviour.pdf

Wardle, H., Seabury, C., Ahmed, H., Payne, C., Byron, C., Corbett, J., Sutton, R. (2014). Gambling behaviour in England and Scotland. Gambling Commission: Birmingham.

Watkins, C. E. (1985) 'Counseling Psychology, Clinical Psychology, and Human Services Psychology: Where the Twain shall meet' . *American Psychologist*, 40 (9), 1054-1056

Willig, C. (2001*).* Interpretative phenomenology in Willig C. *Qualitative Research in Psychology*. Buckingham: Open University.

Willig, C. (2013) *Introducing Qualitative Research in Psychology* (3rd ed.). Maidenhead: Open University Press/ McGraw Hill Education.

Willig, C., & Stainton-Rogers, W. (Eds.) (2008). The SAGE Handbook of Qualitative Research in Psychology. London: Sage.

Wong, G., Zane, N., Saw, A., Chan, & Ki Chan., A. (2012). Examining Gender Differences for Gambling Encouragement and Gambling Problems Among Emerging Adults, *Journal of Gambling Studies*. 29.2: 171-89.

Wood, R, & Griffiths, M,D. (2007a). A qualitative investigation of problem gambling as an escape-based coping strategy, *Psychology and psychotherapy: Theory, research & Practice*, 80: 107 – 125 BPS

Wood, R., & Griffiths, M,D. (2007b). Online guidance, advice, and support for problem gambler and concerned relatives and friends: an evaluation of the GamAid pilot service. *British Journal of Guidance & Counselling*, Vol, 35, No. 4

Woolfe, R., Strawbridge, S., Douglas, B, & Dryden, W. (2014). *Handbook of Counselling Psychology* (3rd ed), London, Sage

Worden, W. (2010). *Grief Counselling and Grief Therapy: A handbook for the mental health practitioner*. (4th ed) East Sussex, Routledge

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.

Yardley, L. (2008). Demonstrating Validity in Qualitative Research. In JA Snurg (Ed.), *Qualitative Psychology, A Practical Guide to Research Methods*. (2nd Ed, pp. 235 – 251) London. Sage Publications.

Yin, R. (1989). *Case Study Research, Design & Methods* (2nd edn). Beverly Hills: Sage.

Appendix A: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

DSM-5 Diagnostic Criteria: Gambling Disorder

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

- Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
- Is restless or irritable when attempting to cut down or stop gambling.
- Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
- Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
- Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
- After losing money gambling, often returns another day to get even ("chasing" one's losses).
- Lies to conceal the extent of involvement with gambling.
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
- Relies on others to provide money to relieve desperate financial situations caused by gambling.
- The gambling behavior is not better explained by a manic episode.

Specify if:

Episodic: Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months.

Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.

Specify if:

In early remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months.

In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer.

Specify current severity:

Mild: 4–5 criteria met.

Moderate: 6–7 criteria met.

Severe: 8–9 criteria met.

From the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (section 312.31).

Appendix B: Problem Gambling Severity Index (PGSI)

Problem Gambling Severity Index

This self-assessment is based on the Canadian Problem Gambling Index. It will give you a good idea of whether you need to take corrective action.

Thinking about the last 12 months…

Have you bet more than you could really afford to lose?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Still thinking about the last 12 months, have you needed to gamble with larger amounts of money to get the same feeling of excitement?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

When you gambled, did you go back another day to try to win back the money you lost?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have you borrowed money or sold anything to get money to gamble?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have you felt that you might have a problem with gambling?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Has gambling caused you any health problems, including stress or anxiety?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Has your gambling caused any financial problems for you or your household?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

Have you felt guilty about the way you gamble or what happens when you gamble?
0 Never. **1** Sometimes. **2** Most of the time. **3** Almost always.

TOTAL SCORE

Total your score. The higher your score, the greater the risk that your gambling is a problem.

Score of 0 = Non-problem gambling.

Score of 1 or 2 = Low level of problems with few or no identified negative consequences.

Score of 3 to 7 = Moderate level of problems leading to some negative consequences.

Score of 8 or more = Problem gambling with negative consequences and a possible loss of control.

Ferris, J., & Wynne, H. (2001). The Canadian problem gambling index: Final report. Submitted for the Canadian Centre on Substance Abuse.

Appendix C: Interview Schedule

1. Can you describe your treatment experience at the [redacted] in as much detail as possible?
2. What does it mean to be seeking or in treatment?
3. Can you describe what motivated you / why you decided to get treatment?
4. What if anything has stopped you seeking help in the past?
5. Has being female affected you experience of treatment options and journey?
6. Can you describe whether your treatment met your expectations and needs?
7. Has treatment changed your experience with gambling?
8. Do you have any thoughts about future treatment / therapy?
9. Are there things you might like to change about your treatment experience?
10. Has anything changed since you completed treatment and to what do you attribute this?

Appendix D: Telephone Screening

What I might say: [redacted] NHS Foundation Trust

I wanted to have a quick chat with you on the phone to make sure you understand what this research is all about and just to make sure everything is completely clear. I also want to ensure that you will be a suitable participant, and match the research requirements. You may also find that once we've gone through my questions you feel it's not something you want to continue with which is fine too. If at any stage you have some questions for me please do ask.

I'm looking for 8 people who are in treatment or have completed treatment at the [redacted] and who are willing to talk about their experience of the therapy in detail. Anything you tell me will remain confidential and this research will not have any impact on any remaining sessions you may have left in treatment. The [redacted] are commissioning this research as they would like to improve their services for females, however all results will remain confidential and this will in no way impact on your treatment plan.

I'm interested in your complete experience of treatment; from the point at which you decided to seek help, how you found out about the clinic, what it was like for you when you first came in for your assessment, what treatment you were offered, where you are up to with your treatment, how you perceive your relationship with your therapist, whether it has been helpful or unhelpful, how you felt, what you were thinking, anything at all however small. I'd also like to hear about how things have been for you in general since you started treatment. I'm keen to hear as much detail as possible, even if you think it's irrelevant.

I have a few questions for you if that's ok.

1. What is your date of birth?
2. Where are you currently living?
4. When did you decide you would like to get help for your gambling?
5. What was the main area of concern for you with your gambling?
6. Where are you up to in your treatment?
7. Do you have any other health or mental health concerns?
8. Do you have any children or dependents?

Now I have another series of questions for you about your current mood if that's okay? (PHQ-9)

http://www.med.umich.edu/1info/fhp/practiceguides/depress/phq-9.pdf

Appendix E: Letter of Support from [redacted]

[redacted]

Email: [redacted]

February 20th 2014

To whom this may concern

This is a letter of support for the proposed qualitative research (by Anna Kaufman) which seeks to explore the experiences of female problem gamblers who have presented for treatment at the [redacted]

Female problem gamblers have been poorly represented in the population attending the [redacted] Alongside the relaxation in UK gambling laws, overall referrals to the [redacted] are increasing by 22% year on year. However female referrals remain stagnant at 7% and females are far more likely to drop out of treatment early with a 53% drop out / DNA rate compared to 33% for men. Although the numbers are currently small, a picture is emerging of a population that differs in some ways to the male population with the suggestion of a degree of increased severity.

Despite efforts to engage this population, including a mailshot campaign and the roll out of a dedicated women's treatment programme, female treatment uptake remains poor. We are obliged under the Equalities Act to continue making efforts to redress this imbalance, yet at present there is limited information or research available to explain the trend we are seeing. Therefore the proposed research would be a timely addition to our own findings at the [redacted] and supports our aims to improve service delivery for clients.

Yours Sincerely

[redacted]

Dr. [redacted]
Consultant Clinical Psychologist &
Service Manager
[redacted]

Appendix F: Recruitment Flyer

CITY UNIVERSITY LONDON

Female problem gamblers wanted for research!

Are you a female who is undergoing treatment here at the [redacted]

I am interested in hearing about your experiences of treatment and which aspects you have found helpful or unhelpful

This will be a chance for you to tell your story at a time and place convenient to you. It will be completely anonymous to protect your privacy. You will only be asked to discuss experiences you are happy to share & will not be pressed to reveal anything you are uncomfortable with.

This will be part of my doctoral research in counselling psychology at City University, London. If you think you may be interested, or would like more information, please email me at:

[redacted]

Emailing me does not mean you are committed to anything!

Travel expenses will be covered for all participants and there will be a gift voucher to say thank you

Appendix G: Participant Information Sheet

CITY UNIVERSITY LONDON

[redacted]

NHS Foundation Trust

Participant information Sheet

Title of study: *Exploring the Experience of Treatment for Female Problem Gamblers*

Thank you for your interest in my project. You are being invited to take part in a research study. Before you decide whether you wish to participate it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Please do ask if there is anything that is not clear and if you would like more information. Take time to decide whether or not you wish to take part.

Part 1: this tells you the purpose of the study and what will happen if you take part

Why I have been invited to participate?
You are being invited to participate as you have a gambling addiction and have attended the [redacted] *within the* [redacted] *and agreed to participate in research at the time of your assessment.*

What is the purpose of the study?
I am gathering information on the treatment experiences of female problem gamblers so as to inform and enhance future treatment programmes. I would like to hear your story and promise to provide a safe, confidential and therapeutic space in which to explore this. The study will form part of a doctorate in counselling psychology that I am undertaking at City University.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and asked to sign a consent form. You are still free to withdraw at any time and don't need to give a reason. You will not be penalized if you do decide to withdraw.

What will happen to me if I take part?
The study will involve one interview session during which you will be asked questions about some of your experiences. The questions will be open ended, to provide the opportunity for you to speak openly about subjects. The session will last up to 1.5 hours and they will usually take place in London at the [redacted]*. In the event that it is difficult for you to get to the* [redacted]*, the interviews will take place at an alternative, mutually agreed venue. During the session you will be interviewed by a researcher about your experiences. The interview will be recorded. Following each interview, you will be given the opportunity to talk to the researcher to discuss any questions or concerns that may have arisen during the interview. You will be offered the opportunity to receive a phone call from me the following day, to provide any further support you may need. The research study is expected to last approximately 18 months in total.*

Will I be paid for my time?
You will be given a token voucher for your time, plus any reasonable travel costs. The reimbursement will be in the form of an M&S gift voucher worth £20 that will be given to you at the end of the interview.

Will participating at the clinic affect my treatment at the [redacted]
No this will have no effect on the treatment that you are receiving or might be offered at the [redacted]*. Although this study is supported by the clinic, the study is separate and the findings will be anonymised.*

What do I have to do?

You will be asked to attend one interview, during which you will be asked some informal questions about your experiences of treatment for problem gambling. We may discuss some personal subjects, but only if you feel comfortable to do so. This is your interview and I would like to be guided by you and things that you feel are pressing.

Are there any risks of taking part?
This study does *not carry any risks to your health and aims to re-create a supportive, therapeutic environment in which we encourage you to speak openly and honestly. In particular, if you feel that you would like some additional support, you will be given information about relevant counselling or support organisations in your area.*

What are the possible benefits of taking part?
Some people find it helpful to discuss their experiences. On a broader scale, future patients could benefit from the findings of this study and the wider community could also benefit from any knowledge that I am able to acquire.

What will happen when the research study stops?
The data will be kept securely for a minimum of 5 years, in accordance with good research practice. After this time data will be destroyed.

What will happen if I don't want to continue with the study?
If you decide to take part you are still free to withdraw from the study at any time without having to explain why. Any data that can be identified as yours will be destroyed if you wish.

Will my GP be informed?
Your GP will not routinely be informed since you are not receiving any medical treatment in this study.

Can I take part?
Several restrictions apply during the study and you will have to follow these carefully, both for your safety and in order not to influence the results of the study.

Female problem gamblers in treatment:
You should be between the age of 18 and 70 years of age.
You should not have a history or prevalence of neurological disorder.
You should not have a diagnosis of schizophrenia or bipolar.

Part 2: this part gives you more detailed information about the conduct of the study
Will my taking part in this study remain confidential?
All information which is collected about you during the course of this research will be kept strictly confidential. The normal principals of confidentiality apply (just as when you visit your doctor) and there are very rare occasions, relating to potential serious harm to self or others when doctors and researchers are obliged to break confidentiality.

What will happen to the study results?
I will analyse and write up the anonymised results which will form part of a research project and may be presented at conferences or/and published in a scientific journal so they are available to other researchers. Direct quotes may be published, however these will not be attributable to any participant as they will be anonymized. The data will be kept securely for a minimum of 5 years, in accordance with good research practice.

Will I get to see the research?
Yes if you would like to receive a copy of the final research, you will be emailed or posted a copy.

Who is organising and funding the research?
The study is being carried out by and funded by a researcher at City University.

Who has reviewed the study?
The study has been reviewed by City University London and by an NHS Research Ethics committee.

What if there is a problem?
If you are unhappy about the conduct of the study and you wish to make a complaint about any aspect of the study, City University London has established a complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is 'Exploring the Experience of Treatment for Female Problem Gamblers'.

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

If you would like more information:
If you have questions about the study or would like to take part, please contact Anna Kaufman for specific details

Anna Kaufman,
Trainee Counselling Psychologist
Tel: [redacted] *Email:*
[redacted]

Dr Jessica Jones Nielsen,
City University,
[redacted]
Tel: [redacted]

Thank you for taking the time to read this information sheet.

Appendix H: Participant Consent Form

CITY UNIVERSITY LONDON

[redacted]

NHS Foundation Trust

Consent Form

Title of Study: Exploring the experience of treatment for female problem gamblers

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve • being interviewed by the researcher • allowing the interview to be audiotaped • making myself available for a further interview should that be required	
2.	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. Direct quotes may be published within the study, however these will not be attributable to me as they will be anonymised. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____	_____	_____
Name of Researcher	Signature	Date
_____	_____	_____
Name of Participant	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix I: Participant Debriefing Form

[redacted]

NHS Foundation Trust

Thank you for taking part in my research and describing some of your experiences of treatment for your gambling addiction, which aims to improve future treatment programs. I really appreciate the time you've given to me. If you have any questions either now or in the future, please don't hesitate to contact me or my supervisor via the contact information supplied to you. If this interview has brought up any sensitive issues for you and you would like to receive a follow up support phone call from me tomorrow, please provide your details for this. The information that you have provided will be kept confidential and no identifiable information will be published. Segments of recorded interviews may be included in the thesis and used in publications. However all data will be anonymised prior to this.

Below you can find information on support services that may be of help to you now or in future.

Charity Services:
Community Action for responsible gambling (CARG)
http://www.cccs.co.uk
Tel: 0800 138 1111
Gam-Anon
www.gamanon.org.uk
Gamblers Anonymous
www.gamblersanonymous.org.uk
Gamcare
www.gamcare.org.uk
Tel: 0808 802 0133
Gordon Moody Association
www.gordonmoody.org.uk
Tel: 01384 241 292
Level Ground Therapy (specialist support for women with a gambling problem)
www.levelgroundtherapy.com
Tel: 0845 2666 658
Mind (advice for anyone with a mental health problem)
www.mind.org.uk
Tel: 0300 123 3393
Money Advice Service
www.moneyadviceservice.org.uk
Tel: 0300 500 5000
Platform 51 (supports women and promotes equality
www.platform51.org
Tel: 01865 304200
Sane
www.sane.org.uk
Helpline: 0207 375 1002
Samaritans
www.samaritans.org
Helpline: 0845 7909 090
NHS Services:
www.nhs.uk/conditions/Counselling/Pages/Introduction.aspx
National Problem Gambling Clinic
www.cnwl.nhs.uk
Tel: 0207 534 6699

Appendix J: Ethics Release Form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc D.Psych X n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Exploring the experience of treatment for female problem gamblers

2. Name of student researcher (please include contact address and telephone number)

Anna Kaufman

[redacted]

3. Name of research supervisor

Dr Jessica Jones Nielsen

4. Is a research proposal appended to this ethics release form? **Yes** No

5. Does the research involve the use of human subjects/participants? **Yes** No

If yes,

a. Approximately how many are planned to be involved? 8

b. How will you recruit them?
From the National Problem Gambling Clinic (NPGC), NHS

c. What are your recruitment criteria?
(Please append your recruitment material/advertisement/flyer)
8 x Female problem gamblers in treatment at the NPGC between 18 – 70 years

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? Yes **No**

d1. If yes, will signed parental/carer consent be obtained? N/A Yes **No**

d2. If yes, has a CRB check been obtained? N/A Yes **No**
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*
Female problem gamblers 2 x 60-90 minute semi-structured interviews

7. Is there any risk of physical or psychological harm to the subjects/participants?
Yes No

If yes,
a. Please detail the possible harm?
There is no risk of physical harm, and although no psychological harm is anticipated, due to the sensitive nature of the subject, it is possible that talking about their experiences may bring up some unexpected and difficult feelings for participants. Measures have been put in place to minimise any psychological harm, including exclusion criteria; telephone screening that will include a PHQ-9 and the transparency of the study.

b. How can this be justified?
I am investigating the phenomenon from a functional stance thus aim to exclude participants who appear vulnerable or who have a history of mental health issues. The informal telephone screening questions will help to exclude inappropriate candidates. An open and transparent explanation of the research will be provided beforehand, to ensure participants fully understand what they are being asked to describe. Questions beyond the scope of the research will not be asked and due to the nature of the methodology, will not be challenging or directive. The participants' experience will guide the direction the interview takes. Participants will not be pressed to reveal anything that they do not wish to share and will be reminded that they can stop the interview at any time. However, if particular topics are excluded from research on the

grounds of potential participant distress, then many important issues will remain under-researched, preventing certain groups from the benefits of potential findings.

c. What precautions are you taking to address the risks posed?

In order to minimise potential distress to unselected participants following the informal telephone screening, steps will be taken to make clear that selection to take part (or not), is dependent on specific research criteria not on personality traits. The pre-selection screening process seeks to exclude those who may be vulnerable with a PHQ-9 assessment to help identify any individuals who are severely depressed and therefore not appropriate to participate at this time. Details of local support services will be supplied after the interview. If participants become visibly upset during the interview, it will be stopped and as an immediate measure I would use my skills as a counselling psychologist trainee to help alleviate or contain their distress, at least on a temporary basis. If they appear to be suffering an emotional crisis, I would keep them safe until I was able to summon professional help. One of the benefits of conducting interviews at the clinic being that there are qualified clinical psychologists and psychiatrists on site. However, this is not anticipated. Participants will not officially be debriefed due to the transparent nature of the research and its aims. However, participants will be offered the chance to ask any questions about the research process immediately after the interview and in the future.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes **No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

There will be digital audio recordings of all participant interviews. Each of these will be transcribed verbatim into word documents and both notes and audio stored electronically. Research notes will be made immediately following each interview.

12. What provision will there be for the safe-keeping of these records?
All audio recordings and computerised notes/transcripts will be encrypted and stored electronically on a hard drive inaccessible from the internet. Any hard copy notes will be kept in a locked cabinet. Private details such as names/addresses will be encrypted and stored electronically, separate from all other information/data.

13. What will happen to the records at the end of the project?
In accordance with City University's ethical requirements, all records will be stored securely for 5 years after the research has been officially completed, at which point it will be permanently destroyed.

14. How will you protect the anonymity of the subjects/participants?
All identifying data such as names/places will be removed or changed to preserve anonymity. The participants' personal information as stated above will be stored securely but separately to research notes and data.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?
A list of psychological services local to each participant will be supplied before the start of the interview process. It is felt that a specific post-research de-brief will be unnecessary due to the open and transparent nature of the research which will be fully explained beforehand. However, participants will be encouraged to ask any questions they may have about the research or the process itself and given contact emails/numbers for myself and my supervisor, should any questions arise later.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher [redacted] Date [redacted]

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? **Yes** No
If yes,

a. Please detail possible harm?

_____

There may be issues around personal safety when meeting previously unknown participants.

b. How can this be justified?
It is considered a small risk, not significantly greater than might be encountered in everyday life. Furthermore, some participants are likely to be found via personal contacts, others through more official channels thus they will be aware that there are ways in which they can be traced were any incident to occur.

c. What precautions are to be taken to address the risks posed?
I will use a personal alarm as provided at the NPGC for any interviews conducted on site. This would alert the team to any danger. For any participants who are unable to meet at the clinic, where possible, I will arrange to conduct interviews in private areas of public spaces such as rooms at the university.

Section C: To be completed by the research supervisor
(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature [redacted] Date [redacted]

Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature [redacted] Date [redacted]

Appendix K: R&D Governance Approval Letter

noclor NHS
Research Support Service

Bedford House, 3rd Floor
125-133 Camden High Street
London, NW1 7JR

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclor.nhs.uk

13 May 2014

Mrs Anna Kaufman
Department of Psychology
Social Sciences Building
City University London
Whiskin Street
London
EC1R 0JD

Dear Anna

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in **the trust identified below**:

Study Title: Exploring the experience of treatment for female problem gamblers
R&D reference: 144030
REC reference: 14/WA/0128

This NHS Permission is based on the REC favourable opinion given on **16 April 2014** and the subsequent minor amendments to the Participant Information Sheet and Consent form as advised by Noclor R&D office, details as follows:

- Participant Information Sheet, Version 3, 27.04.2014
- Consent form, Version 2, 27.04.2014

Name of the trust	Name of current PI/LC	Date of permission issue(d)
[redacted] NHS Foundation Trust	Anna Kaufman	13 May 2014

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely

[redacted]
Research Operations Manager

Cc: Dr Jessica Jones Nielsen, Academic Supervisor
Anna Ramberg, Sponsor Contact

noclor NHS
Research Support Service

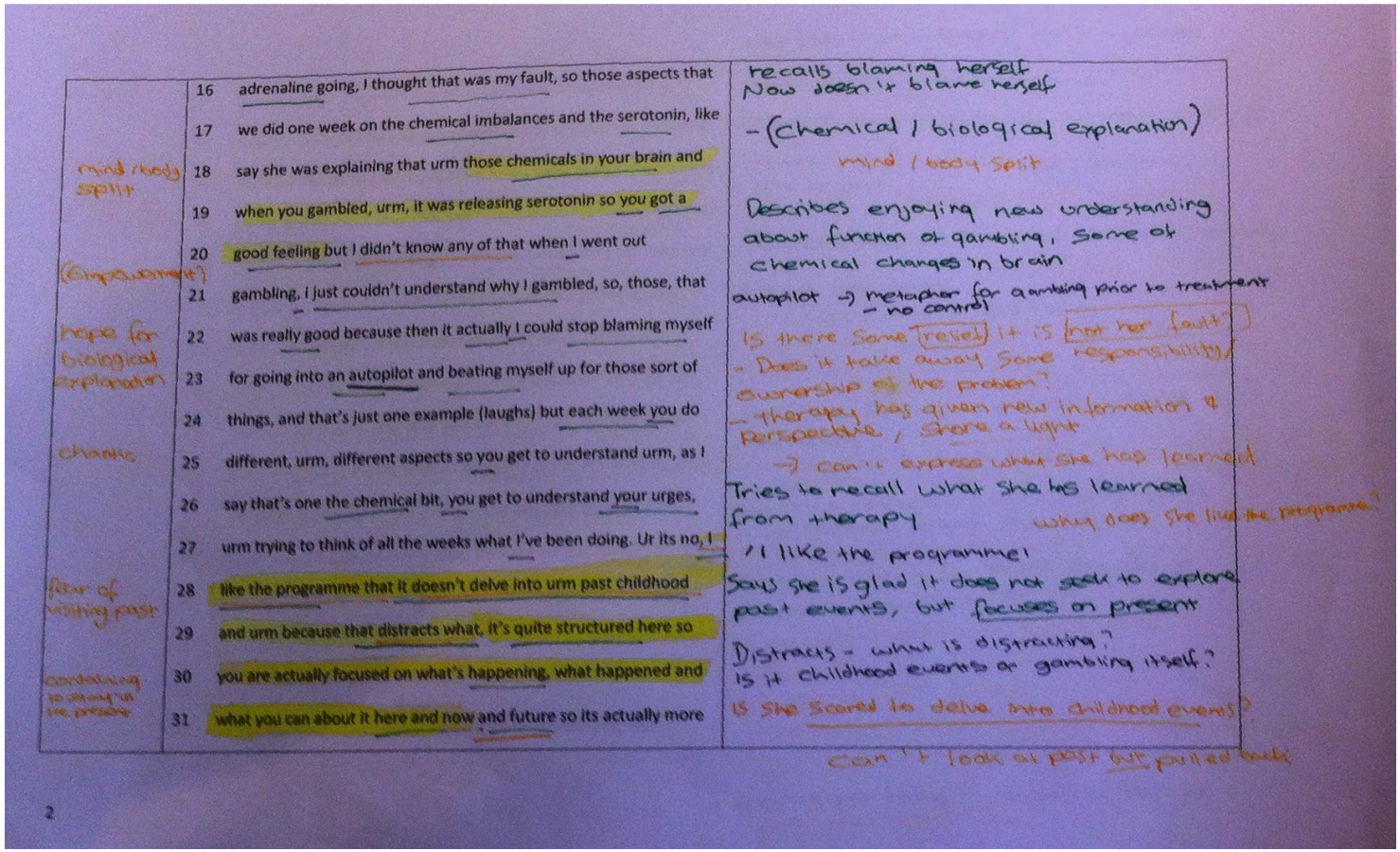
Bedford House, 3rd Floor
125-133 Camden High Street
London, NW1 7JR

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclor.nhs.uk

May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website: http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment.
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

Appendix L: Extract of Transcript

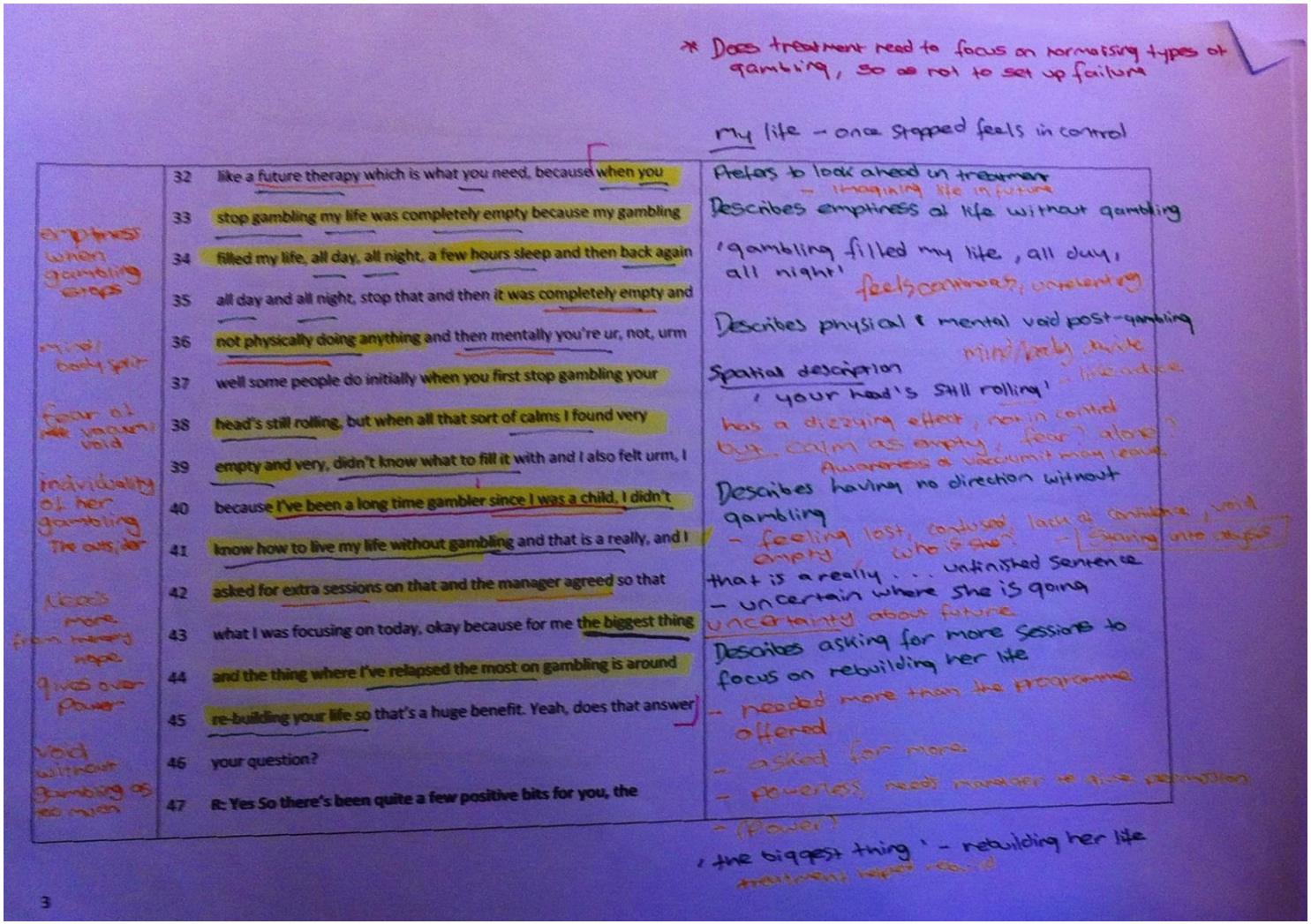


16 adrenaline going, I thought that was my fault, so those aspects that
17 we did one week on the chemical imbalances and the serotonin, like
18 say she was explaining that urm those chemicals in your brain and
19 when you gambled, urm, it was releasing serotonin so you got a
20 good feeling but I didn't know any of that when I went out
21 gambling, I just couldn't understand why I gambled, so, those, that
22 was really good because then it actually I could stop blaming myself
23 for going into an autopilot and beating myself up for those sort of
24 things, and that's just one example (laughs) but each week you do
25 different, urm, different aspects so you get to understand urm, as I
26 say that's one the chemical bit, you get to understand your urges,
27 urm trying to think of all the weeks what I've been doing. Ur its no, I
28 like the programme that it doesn't delve into urm past childhood
29 and urm because that distracts what, it's quite structured here so
30 you are actually focused on what's happening, what happened and
31 what you can about it here and now and future so its actually more

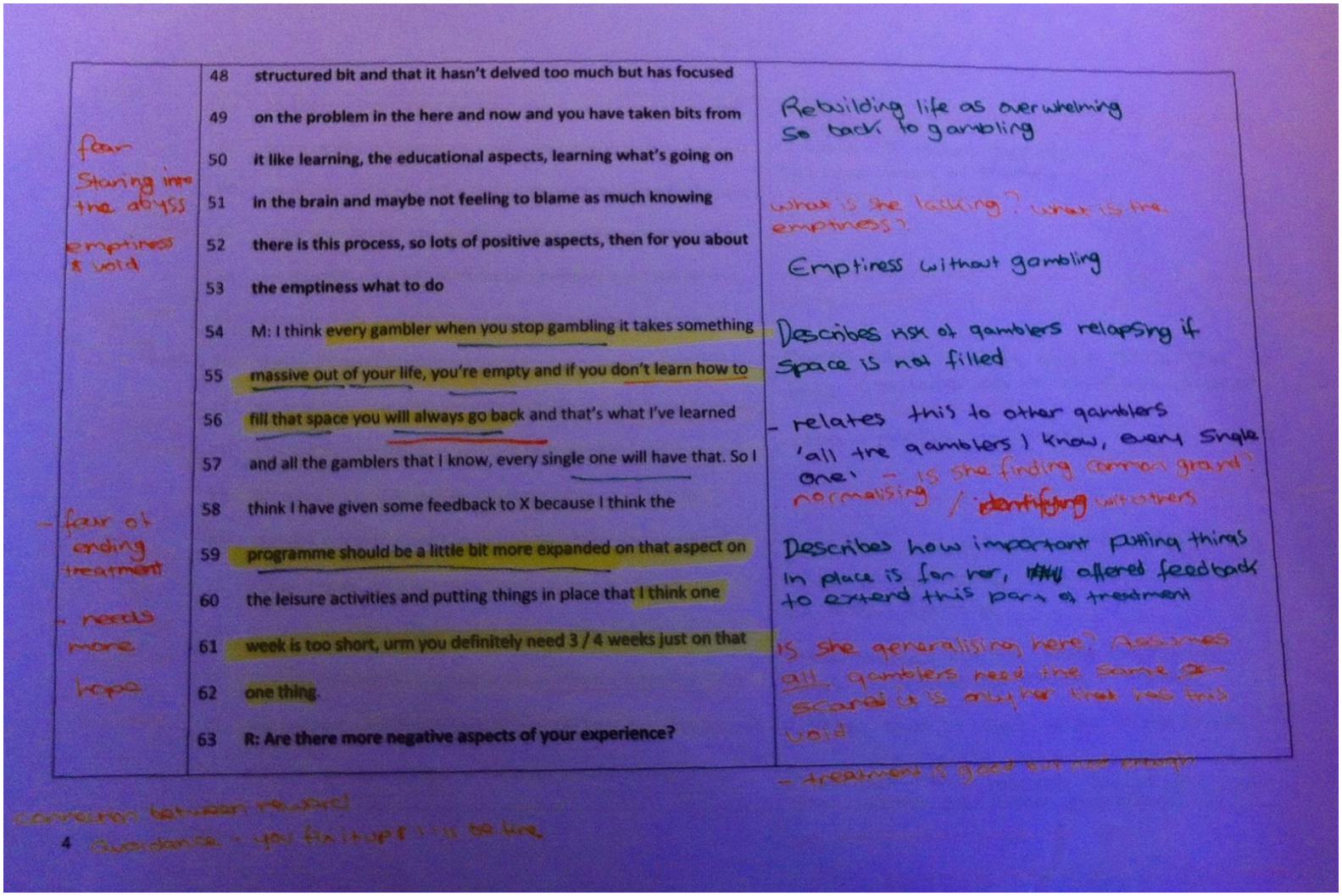
recalls blaming herself
Now doesn't blame herself
-(Chemical / biological explanation)
mind / body split
Describes enjoying new understanding about function of gambling, Some of chemical changes in brain
autopilot -> metaphor for gambling prior to treatment - no control
Is there some relief it is [not her fault]
- Does it take away some responsibility/ ownership of the problem?
- therapy has given new information & Perspective / Shone a light
-> can't express what she has learned
Tries to recall what she has learned from therapy
why does she like the programme?
'I like the programme'
Says she is glad it does not seek to explore past events, but focuses on present
Distracts - what is distracting? Is it childhood events or gambling itself?
Is she scared to delve into childhood events?
can't look at past but pulled back

mind/body split
(Empowerment)
hope for biological explanation
chaotic
fear of visiting past
continuing to distance us from present

2



	32	like a future therapy which is what you need, because when you
	33	stop gambling my life was completely empty because my gambling
	34	filled my life, all day, all night, a few hours sleep and then back again
	35	all day and all night, stop that and then it was completely empty and
	36	not physically doing anything and then mentally you're ur, not, urm
	37	well some people do initially when you first stop gambling your
	38	head's still rolling, but when all that sort of calms I found very
	39	empty and very, didn't know what to fill it with and I also felt urm, I
	40	because I've been a long time gambler since I was a child, I didn't
	41	know how to live my life without gambling and that is a really, and I
	42	asked for extra sessions on that and the manager agreed so that
	43	what I was focusing on today, okay because for me the biggest thing
	44	and the thing where I've relapsed the most on gambling is around
	45	re-building your life so that's a huge benefit. Yeah, does that answer
	46	your question?
	47	R: Yes So there's been quite a few positive bits for you, the



48 structured bit and that it hasn't delved too much but has focused
49 on the problem in the here and now and you have taken bits from
50 it like learning, the educational aspects, learning what's going on
51 in the brain and maybe not feeling to blame as much knowing
52 there is this process, so lots of positive aspects, then for you about
53 the emptiness what to do
54 M: I think every gambler when you stop gambling it takes something
55 massive out of your life, you're empty and if you don't learn how to
56 fill that space you will always go back and that's what I've learned
57 and all the gamblers that I know, every single one will have that. So I
58 think I have given some feedback to X because I think the
59 programme should be a little bit more expanded on that aspect on
60 the leisure activities and putting things in place that I think one
61 week is too short, urm you definitely need 3 / 4 weeks just on that
62 one thing.
63 R: Are there more negative aspects of your experience?

fear
Staring into the abyss
emptiness & void
- fear of ending treatment
- needs more hope

Rebuilding life as overwhelming
So back to gambling

What is she lacking? What is the emptiness?

Emptiness without gambling

Describes risk of gamblers relapsing if space is not filled

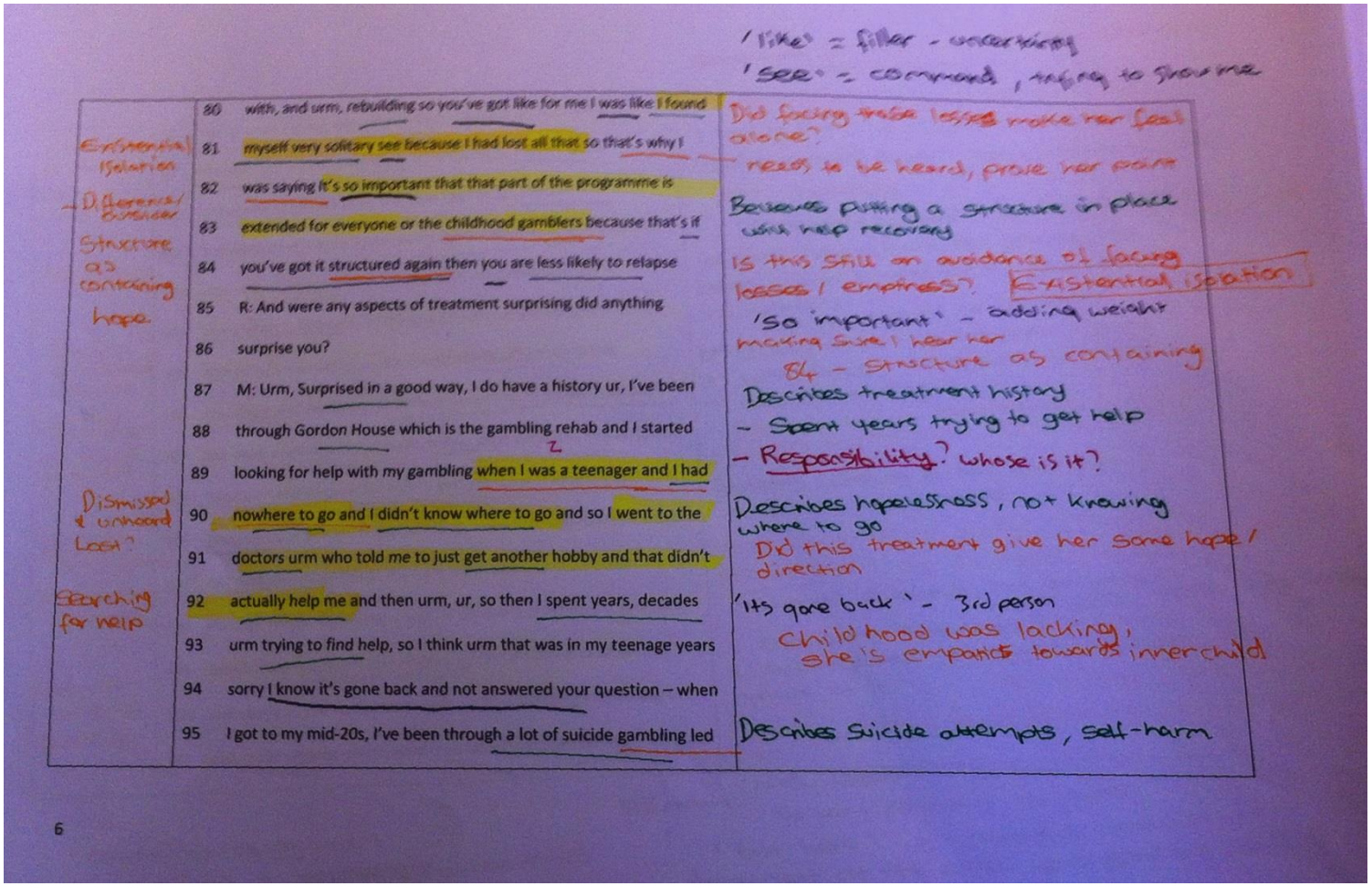
- relates this to other gamblers 'all the gamblers I know, every single one' - is she finding common ground? normalising / identifying with others

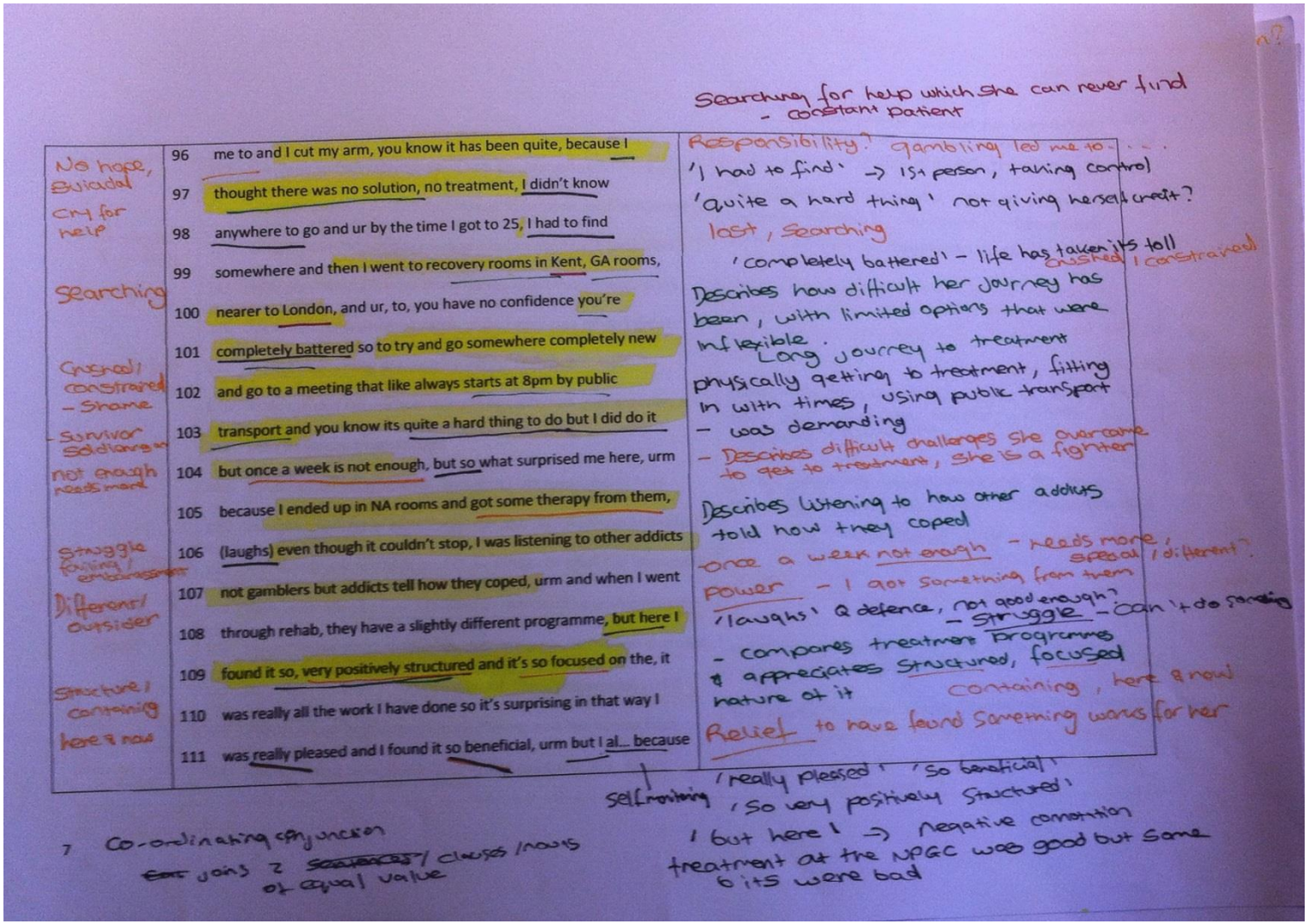
Describes how important putting things in place is for her, offered feedback to extend this part of treatment

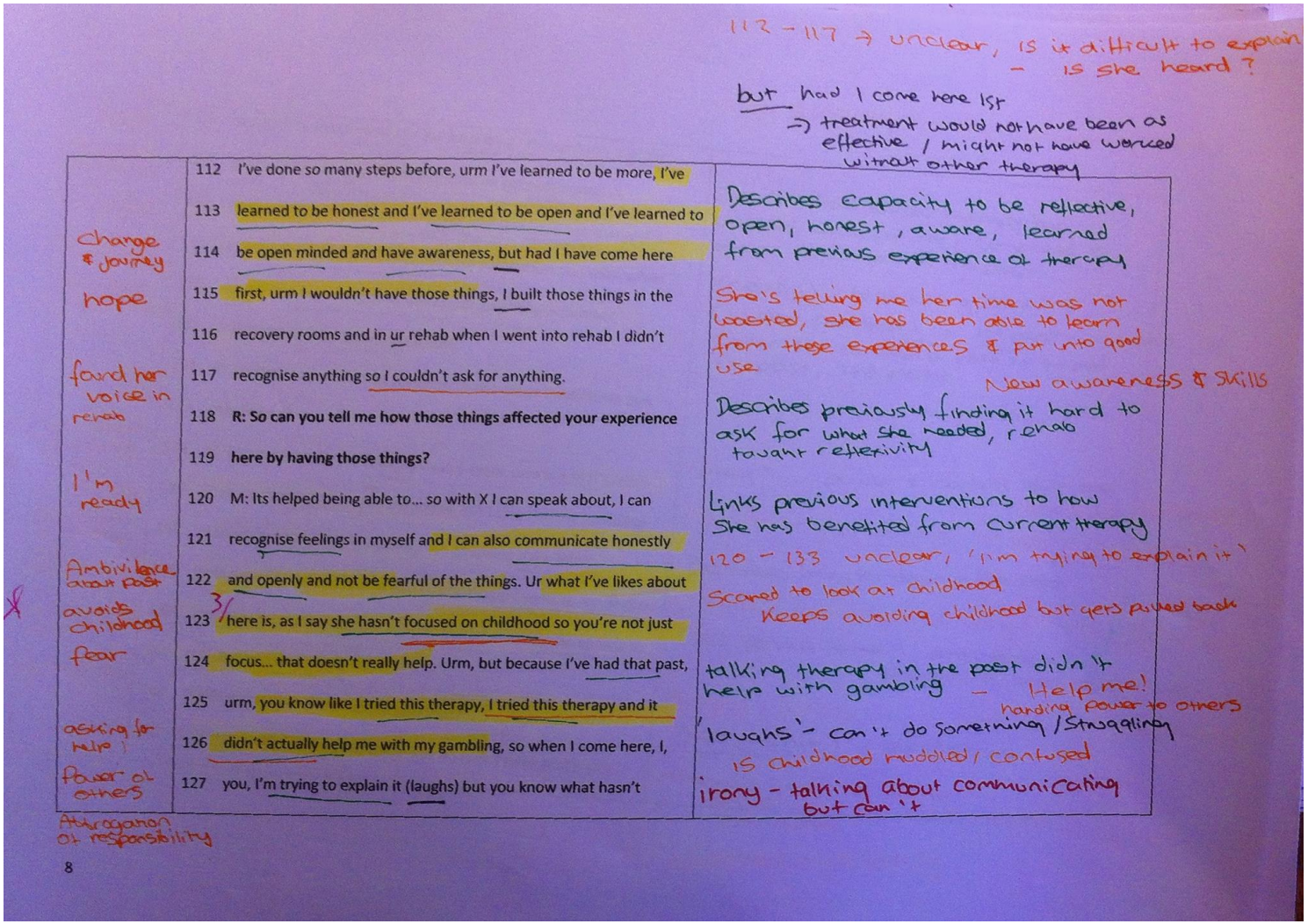
Is she generalising here? Assumes all gamblers need the same or scared it is only her that has this void

- treatment is good but not enough

connection between reward
4 avoidance - you fix it up it's so like.


'like' = filler - uncertainty
'see' = command, trying to show me
Existential Isolation
Difference/ Outsider
Structure as containing hope
Dismissed & unheard
Lost?
Searching for help
80 with, and urm, rebuilding so you've got like for me I was like I found
81 myself very solitary see because I had lost all that so that's why I
82 was saying it's so important that that part of the programme is
83 extended for everyone or the childhood gamblers because that's if
84 you've got it structured again then you are less likely to relapse
85 R: And were any aspects of treatment surprising did anything
86 surprise you?
87 M: Urm, Surprised in a good way, I do have a history ur, I've been
88 through Gordon House which is the gambling rehab and I started
89 looking for help with my gambling when I was a teenager and I had
90 nowhere to go and I didn't know where to go and so I went to the
91 doctors urm who told me to just get another hobby and that didn't
92 actually help me and then urm, ur, so then I spent years, decades
93 urm trying to find help, so I think urm that was in my teenage years
94 sorry I know it's gone back and not answered your question – when
95 I got to my mid-20s, I've been through a lot of suicide gambling led
Did facing these losses make her feel alone?
need to be heard, prove her point
Believes putting a structure in place will help recovery
Is this still an avoidance of facing losses / emptiness?
Existential isolation
'so important' - adding weight making sure I hear her
84 - structure as containing
Describes treatment history
- Spent years trying to get help
- Responsibility? whose is it?
Describes hopelessness, not knowing where to go
Did this treatment give her some hope / direction
'Its gone back' - 3rd person
Childhood was lacking, she's empathic towards inner child
Describes suicide attempts, self-harm
6


Searching for help which she can never find
- constant patient
No hope, Suicidal
Cry for help
Searching
Ashamed / constrained
- Shame
- Survivor
not enough needs more
Struggle failing / embarrassment
Different / outsider
Structure / containing here & now
96 me to and I cut my arm, you know it has been quite, because I
97 thought there was no solution, no treatment, I didn't know
98 anywhere to go and ur by the time I got to 25, I had to find
99 somewhere and then I went to recovery rooms in Kent, GA rooms,
100 nearer to London, and ur, to, you have no confidence you're
101 completely battered so to try and go somewhere completely new
102 and go to a meeting that like always starts at 8pm by public
103 transport and you know its quite a hard thing to do but I did do it
104 but once a week is not enough, but so what surprised me here, urm
105 because I ended up in NA rooms and got some therapy from them,
106 (laughs) even though it couldn't stop, I was listening to other addicts
107 not gamblers but addicts tell how they coped, urm and when I went
108 through rehab, they have a slightly different programme, but here I
109 found it so, very positively structured and it's so focused on the, it
110 was really all the work I have done so it's surprising in that way I
111 was really pleased and I found it so beneficial, urm but I al... because
Responsibility? gambling led me to...
'I had to find' -> 1st person, taking control
'quite a hard thing' not giving herself credit?
lost, Searching
'completely battered' - life has taken its toll
Describes how difficult her journey has been, with limited options that were inflexible.
Long journey to treatment
physically getting to treatment, fitting in with times, using public transport
- was demanding
- Describes difficult challenges she overcame to get to treatment, she is a fighter
Describes listening to how other addicts told how they coped
Once a week not enough - needs more, special / different?
Power - I got something from them
'laughs' Q defence, not good enough?
- Struggle - can't do forever
- compares treatment programmes
& appreciates structured, focused nature of it
containing, here & now
Relief to have found something works for her
self-monitoring
'really pleased' 'so beneficial'
'so very positively structured'
'but here' -> negative connotation
treatment at the NPGC was good but some bits were bad
7 Co-ordinating conjunction
joins 2 clauses / nouns of equal value



	112 I've done so many steps before, urm I've learned to be more, I've	
	113 learned to be honest and I've learned to be open and I've learned to	Describes capacity to be reflective, open, honest, aware, learned from previous experience of therapy
change & journey	114 be open minded and have awareness, but had I have come here	
hope	115 first, urm I wouldn't have those things, I built those things in the	She's telling me her time was not wasted, she has been able to learn from these experiences & put into good use
	116 recovery rooms and in ur rehab when I went into rehab I didn't	
found her voice in rehab	117 recognise anything so I couldn't ask for anything.	Describes previously finding it hard to ask for what she needed, rehab taught reflexivity
	118 **R: So can you tell me how those things affected your experience**	
	119 **here by having those things?**	
I'm ready	120 M: Its helped being able to... so with X I can speak about, I can	Links previous interventions to how she has benefited from current therapy
	121 recognise feelings in myself and I can also communicate honestly	
Ambivalence about past	122 and openly and not be fearful of the things. Ur what I've likes about	
avoids childhood	123 here is, as I say she hasn't focused on childhood so you're not just	
fear	124 focus... that doesn't really help. Urm, but because I've had that past,	talking therapy in the past didn't help with gambling
	125 urm, you know like I tried this therapy, I tried this therapy and it	
asking for help	126 didn't actually help me with my gambling, so when I come here, I,	'laughs' - can't do something / Struggling
Power of others	127 you, I'm trying to explain it (laughs) but you know what hasn't	irony - talking about communicating but can't

Abbreviation of responsibility

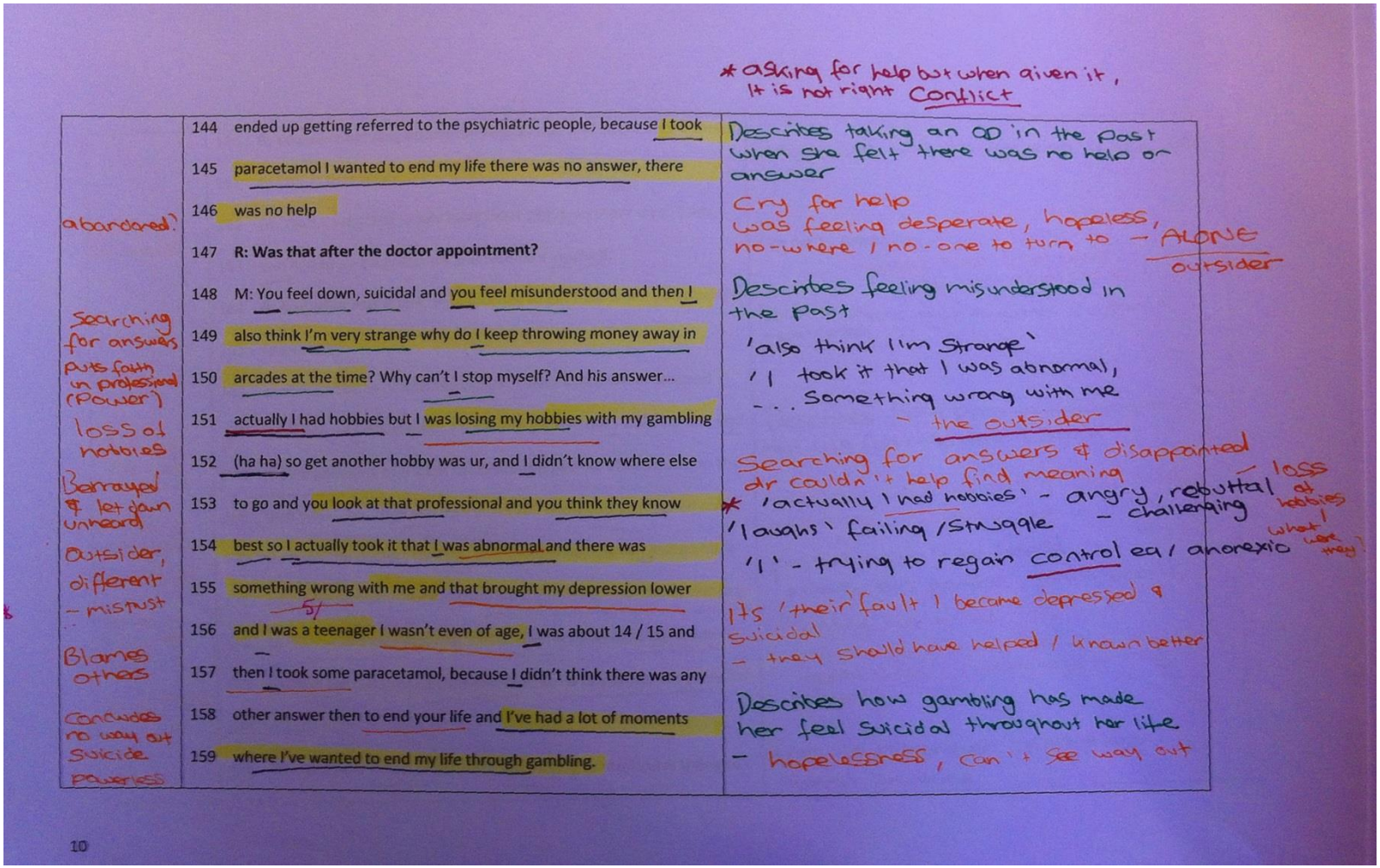
8

Is she surprised she found something good?

hope	128 worked, so that's what I found surprising I thought this is really	
current treatment as meaningful	129 good, this is really spot on, and they've got really good ur	Describes how NPGC therapy has worked well for her, compared to other treatment in the past
Comparing treatments	130 programme and its designed really well and I can see that and it,	'really' - highlighting benefits
Had poor expectations	131 and ur, so that surprised me because sometimes you think when	'I can see that' - 1st person, in control
	132 you go to new urm type of therapy or gambling treatment,	Contrasts to when it hasn't helped in past, 3rd person'
	133 sometimes it hasn't been beneficial	
	134 **R: In what ways does this compare to the other treatments you**	
	135 **mentioned?**	
childhood lacking care - shame	136 M: I've been under the NHS psychiatry team, urm but that's more	'they' - power / control given over
	137 because I had a problem in childhood, but I also had the gambling	Childhood darkness
Betrayal of let down by professional	138 problem but they didn't touch on the gambling they didn't	not feeling understood by people in power
	139 understand it and as I said to you as a teenager I went to my doctor	Describes being let down in the past
who serves who?	140 so desperate and he said get another hobby, that was his service to	139-141 repetition of story (91-93) Significant
	141 me, that was really shit.	'his service to me' entitlement? Something being done to her
abandoned?	142 **R: What was that like when he said that?**	Angry, furious was unheard, dismissed
	143 M: I was suicidal at the time there was no urm. I think that's why I	'really shit' - expletive

victim, blaming doctor?
She should have been helped as she asked

childhood was lacking


* asking for help but when given it, it is not right Conflict
144 ended up getting referred to the psychiatric people, because I took
145 paracetamol I wanted to end my life there was no answer, there
146 was no help
147 R: Was that after the doctor appointment?
148 M: You feel down, suicidal and you feel misunderstood and then I
149 also think I'm very strange why do I keep throwing money away in
150 arcades at the time? Why can't I stop myself? And his answer...
151 actually I had hobbies but I was losing my hobbies with my gambling
152 (ha ha) so get another hobby was ur, and I didn't know where else
153 to go and you look at that professional and you think they know
154 best so I actually took it that I was abnormal and there was
155 something wrong with me and that brought my depression lower
156 and I was a teenager I wasn't even of age, I was about 14 / 15 and
157 then I took some paracetamol, because I didn't think there was any
158 other answer then to end your life and I've had a lot of moments
159 where I've wanted to end my life through gambling.
abandoned
Searching for answers puts faith in professional (Power)
loss of hobbies
Betrayed & let down unheard
Outsider, different - mistrust
Blames others
Concludes no way out Suicide Powerless
Describes taking an OD in the past when she felt there was no help or answer
Cry for help
was feeling desperate, hopeless, no-where / no-one to turn to - ALONE
outsider
Describes feeling misunderstood in the past
'also think I'm Strange'
'I took it that I was abnormal, ... Something wrong with me
- the outsider
Searching for answers & disappointed dr couldn't help find meaning
* 'actually I had hobbies' - angry, rebuttal
- loss of hobbies
'laughs' failing / Struggle - challenging
what were they?
'I' - trying to regain control eg / anorexia
Its 'their' fault I became depressed & suicidal
- they should have helped / known better
Describes how gambling has made her feel suicidal throughout her life
- hopelessness, can't see way out

Appendix M: Extract from Table of Themes for Participant 6

Cluster	Theme	Page and line number	Quote / keyword
The outsider, misunderstood	Not feeling understood	P 13, L 207	Other people **don't understand** what you're going through
	Grievance, feeling misunderstood	P 22, L342	I was very upset, angry that she had no idea about addiction, yet it was one of the main reasons why they were involved with my family
	Not feeling understood	P 20, L 305	And one social worker said to my face that **she doesn't see why I do** it either. She doesn't see why I can't just say to myself that I'm not going to gamble, which hurt a lot.
	Not feeling understood	P 21, L 327	**Not being understood** was very difficult because I lived with my husband, and his attitude was basically, I know how you quit gambling, don't go into an arcade
	Not feeling understood	P 20, 314	I think one of the hardest things I have found with it, it's the fact that people, most people, unless they have been there or know someone who has been there **they don't understand** how difficult it is
	Not feeling understood	P 19, 302	I think the hardest thing to cope with is that it's not understood very well
	Not feeling understood,	P 21, L 331	And it was seeing his reaction when he's supposed to be someone that loves me that **he couldn't understand** that you could be addicted to this kind of thing
	Dismissed, not understood	P 25, L 387	**He doesn't really understand** the extent of my gambling, I remember when it came out of the social report that I'd spent over £100,000 on gambling and he was like oh that can't be true..there's no way you could have spent that much money, so I denied it
Alone	Feeling alone, distanced	P 13, L 194	The journey for me to the appointment was probably about an hour and a half and sometimes I'd get quite upset and I didn't want to have to travel back on the edge of being upset on my own
Inaccessibility Too far away	After group as inaccessible, too far away (distance a problem), feeling isolated	P 2, L 24	There was an after group but unfortunately it was in the evenings and as it was in London I wasn't able to attend
	Group as inaccessible, too far away	P 2, L 27	So that was the downside, I feel that I needed further help but I couldn't

	(distance a problem), feeling isolated		access it because of how far away it was and because it was late
	Group too far away, stigmatised as gambler	P 3, L 44	You can get help for drugs and alcohol but gambling there isn't much help available. London was the nearest one I could fine
Children as block to treatment	Gender issue – children preventing access	P 5, L 76	I think being a single female has because of the childcare side of it…unless there was something available at the meetings I wouldn't want to leave them with anybody
	Gender issue – children preventing access	P 6, L 82	I think if I had had my baby whilst getting treatment I don't think I could have carried it through unless I could have taken it with me
	Gender issue – children preventing access	P 6, L 88	For me as a woman it was the childcare side of things that was most difficult
Secrets	Pretending to be something to access alcohol services	P 17, L 261	I've actually started an AA meeting, not because I drink but because they do the 12 step programme and because I've got social services back involved with our family
	Pretending to be alcoholic to access services, Previous drinking problems	P 17, L 268	I have made some friends which does make it easier, although they think I am an alcoholic which I have had problems with in the past. They don't know I have other issues
	Pretending to be alcoholic to access services, looking for identification	P 18, L 278	I'd rather be with the same group who has the same issues I had, not alcohol, but its helping at the moment until I can find somewhere local that can take me on with childcare
	Secrets, family deceit and relinquished responsibility, seems **unapologetic – holds nan responsible?**	P 20, L 316	Urm, I find it quite a secretive thing on my life, I mean I've had to lie lots to get money from my family
	Secrets, not understanding (out of control)	P 27, L 423	Growing up I used to do a lot of stuff with my dad and he would give me a lift to college and a lift home but we couldn't let my mum know and **I never understood why**
	Secrets, relinquished responsibility	P 28, L 442	**It's quite difficult to know** if it's the addiction that's caused me to be secretive,,, or whether it's because it is how my family is

	Secrets, relinquished responsibility	P 28, L 445	Even now we're having to keep secrets from my older boy because we don't want my husband knowing where we are
	Secrets, in hiding from husband	P 29, L 451	I don't want him knowing where we are…so even now where you look at my life and it isn't to do with gambling but I still feel that I need to lie.
	Gambling as an **invisible** addiction, shame	P 22, L 347	Yeah I think it's one of the addictions that is pushed aside because it is so secretive. You can tell if someone's an alcoholic…you can tell if someone's on drugs because you can see it, you can't tell if someone gambles.
	Mistrust of others, shame	P 22, L 337	It would take a lot of trust before I would tell someone, urm that I have an issue
	Mistrust of others, temporal (waiting)	P 18, L 284	and then you have people who don't say anything for weeks and weeks and weeks and you feel you have made yourself quite vulnerable whereas other people are just sitting there
	Mistrust of others	P 19, L 294	You do get worried who's at these groups, who knows your ex, will they go back and say something
	Mistrust of others	P 19, 297	So that's the bit I find difficult in groups, its being able to trust the people you're with as well
Money buying love	Money to buy time / more!	P 8, L 120	Some days when I walked out and had a lot of money **I couldn't explain how I felt,** I was excited **it was everything**, erm and quite a big part of that was that **I was going to have quite a bit more money to go back in another day**
	Couldn't **spend** winnings on son, fear of ending? conflict	P 8, L 124	My thoughts were in there oh great I'll be able to buy my child something but when it actually came to it I couldn't spend the money
	Money to buy love	P 28, L 435	I would get money from my parents and gamble it and they didn't think anything of it
	Avoidance of looking at self?	P 33	I'm still not great with money, I never was, but it's made me think a lot more about it
Embodied	Mind / body split	P 12, L 178	I find in counselling you sort of open your heart a lot
	Mind / body split, temporal (waiting)	P 18, L 283	You spill your heart out
	Mind / body split	P 19, L 292	Spilling your heart out
	Mind / body split	P 20, 311	Its more your brain getting the thrills and stuff

Appendix N: Master Table

Master theme	Subtheme	Sub-Subtheme	Amy	Alice	Beth	Catherine	Diane	Emma	Natalie	Jacqui
Running from the pain of loss	Early Loss and separation			112, 107, 113, 115, 499	594, 316, 339, 365, 312, 632, 89, 439, 546, 538	23, 220, 421, 60, 368, 23, 430, 220, 421		211	74, 399	82, 96, 131, 370, 370, 241, 459
	Loss of identity as problem gambler		546, 528, 36, 340, 228, 213, 432, 332	120, 240, 280, 321, 335, 89, 93, 142, 103, 432	290, 567, 40, 71, 375, 289, 509, 518, 57, 254	63, 64, 71, 129, 58, 100	383, 102, 104, 106, 107, 174	164, 178, 200, 202	53, 56, 235, 39, 351, 373, 50	22, 33, 419, 76, 94, 250, 203
	Staring into the Abyss		179, 181, 414, 35, 8, 388, 41, 449, 274	214, 485, 277, 346, 489, 582, 214, 534	41, 551, 60, 608, 274, 279, 286, 534, 542, 584, 141, 60, 608, 33, 38, 43, 54, 35	490, 407, 21, 167, 31, 36, 133, 145, 198, 153, 171, 180, 20, 209, 278, 323, 494	89, 91, 306, 313, 331	98, 143, 149, 151, 289, 274, 277, 280, 99, 306	33, 279, 426	250, 241, 415, 76, 428, 441
The conflict of seeking help	Becoming a patient	Independence Vs dependence	447, 461, 57	211, 26, 50, 417, 233, 129, 125	89, 139, 263	253, 603, 194, 486, 237, 455	40, 71, 240, 142, 134, 144, 161, 341, 118, 304	98, 151, 289, 40, 216, 188	172, 35, 41, 138, 319, 140, 343, 298, 246, 256, 396, 53, 236,	116, 128, 250
		Relinquished Responsibility vs Ownership of Problem	8, 388, 41, 449, 19, 94, 26, 135, 241, 277, 442,	206, 26, 50, 136, 417, 57, 129, 404, 321, 261,	440, 28, 567, 36, 651, 7, 18	442, 33, 28, 99, 230, 493, 100, 67, 71, 129, 323, 494, 457, 98, 50, 311	161, 312, 335, 214, 135	5, 37, 3, 29, 35, 211, 215, 20, 160, 189, 171, 325, 16	44, 103, 105, 197, 298, 294, 134, 224, 122, 325, 277, 288, 409, 279, 293, 426, 298, 351,	213, 92, 391, 76, 198, 425, 426, 145, 198, 250, 391, 441

			179, 7, 108, 5, 449	267, 496, 129					22, 28, 43, 106, 209, 292	
		Secrecy vs Honesty	310, 106, 41	424, 241, 248, 253, 87, 210, 117, 442	112, 121, 240, 105, 215	261, 268, 278, 316, 423, 442, 445, 451, 347, 294, 297, 223, 507, 333, 387, 221359	130, 202, 13	208, 197, 202, 475	164, 255, 169, 188, 213, 210, 6, 396, 309	102
		Avoidance vs Experiencing Feelings	390, 349, 81, 361, 81, 119, 123, 329, 134, 138, 352, 366	81, 117, 316, 331, 343, 375, 377, 388, 391, 409, 489, 532, 125, 81, 496, 20	230, 488, 492, 96, 158, 296, 389, 382, 255, 513, 27, 122, 369, 431, 335428, 509, 518	455, 244, 515, 232	67, 232, 345, 249, 79, 209, 315, 344, 267, 155, 126, 247, 202	191, 188, 180, 198, 313, 353, 325, 330, 101, 108, 306, 261, 328, 202	279, 466, 343	331, 333, 345, 121
	Barriers to treatment		116, 123, 77, 123, 106, 138	168, 158, 4, 52, 40, 158, 59,	320, 325, 453, 456, 478, 99, 175, 101, 240, 236, 299, 143	24, 27, 44, 76, 82, 88, 194	77, 149, 24, 28, 33, 34, 45, 49, 60, 245, 145, 43	3, 5, 59, 288, 202	306, 314, 3, 210, 16, 221, 65	150, 145, 460, 92
	Helpful and Unhelpful aspects of Treatment		67, 176, 447, 94, 26, 29, 60, 127, 248, 135, 241, 256, 289, 293, 361, 461, 77, 81, 119, 116, 123, 150, 170, 258, 261, 273, 461	17, 11, 211, 277, 292, 485, 235, 45, 201, 78, 87, 210, 303, 306, 404, 168, 158, 404, 168, 158, 4, 52, 40, 158, 59, 117	10, 108,112, 121, 129, 394, 404, 13, 41, 551, 60, 101, 60, 82	120, 191, 13, 21, 113, 159, 163, 486, 296, 223, 507, 333, 237, 9, 490, 455, 29, 245, 66	252, 22, 66, 77, 19, 24, 28, 33, 34, 45, 49, 60, 245, 145, 464, 178, 33, 455, 24, 245	8, 13, 111, 113, 158, 16, 17, 20, 27, 29, 139, 270, 294, 296, 313, 316, 344, 353, 357, 364, 274, 277, 280, 19 , 101, 306, 19	3, 210, 141, 224, 325, 210, 36, 84, 122, 277, 283, 8, 15, 71, 26, 6, 30, 77, 177, 497, 204, 58, 114, 505, 36, 41	194, 213, 239, 241, 259, 426, 435, 40, 284, 46, 5, 9, 48, 52, 56, 268, 59, 67, 273, 276, 89, 145, 289, 357, 360, 361, 365, 460,

										342, 150, 150
Negotiating Relationships	The outsider		94, 426, 261, 273, 170, 258, 261, 273, 145, 421	177	10, 80, 266, 272, 550, 594, 12, 14, 36, 36, 179, 182, 494, 148	207, 342, 305, 327, 314, 302, 331, 387, 194	11, 278, 264, 267, 282, 30, 278	19, 54, 68, 72, 183, 252, 115, 118, 224, 229, 236, 87, 267, 105, 256	196, 67	14, 15, 27, 31, 375, 384, 467, 9, 342, 384, 289, 357, 361, 365, 460, 380
	Boundaries and power dynamics		49, 57, 57, 190, 51, 57, 190, 203, 51, 57, 411	182, 195, 281, 20, 26	141, 12, 14, 249, 208, 312, 139, 153, 342, 393, 502, 347, 345, 352, 360, 371, 58	337, 284, 296, 316, 294, 8, , 430, 364, 24, 362, 385	13, 73	183, 184, 248, 266, 180, 179, 208	51, 86, 155, 447, 332, 455, 23, 368, 147, 130, 339, 301, 344, 144, 416, 132, 137, 325, 177, 343, 371, 351, 185, 153, 330, 350, 444, 508	9, 102, 315, 319, 354, 324, 407, 410, 415, 48, 109, 302, 306, 309, 315, 441, 447, 455, 486, 490, 128, 342, 384, 116, 331, 333
	Stigma & gendered expectations		301, 307, 310, 84, 143, 421, 503	175	272, 179, 182, 481, 494, 512, 249	44, 76, 82, 88, 347	30, 56, 234	105, 124, 224, 236	188, 23, 368, 180	14, 15, 379

Appendix P: Student Poster Prize Certificate

The British
Psychological Society
Division of Counselling Psychology

DIVISION OF
COUNSELLING PSYCHOLOGY
Annual Conference 2014
Student Poster Prize Winner

This is to certify that

Anna Kaufman

was the winner of the Student Poster Prize
competition for her work entitled
**'The experience of treatment
for female problem gamblers'**

etc.venues, Victoria, London
11–12 July 2014

Helen Nicholas
Chair, Division of Counselling Psychology

Incorporated by Royal Charter

SECTION C – PUBLISHABLE PAPER

Barriers to Treatment for Female Problem Gamblers: A UK Perspective

Barriers to treatment for female problem gamblers: A UK perspective[4]

Anna Kaufman[a,*]✉, Jessica D. Jones Nielsen[a] and Henrietta Bowden-Jones[b]
[a]*Department of Psychology, City University London, Northampton Square, London EC1V 0HB, United Kingdom*
[b]*Faculty of Medicine, Department of Medicine, Imperial College London, London SW7 2AZ*

Abstract There is a paucity of research in the UK which examines problem gambling and that which does exist is mainly quantitative, focuses on male samples and fails to look at treatment seeking populations or obstacles preventing problem gamblers from seeking treatment. This paper presents findings from part of a larger qualitative study that explored the experience of treatment for female problem gamblers. Data were collected using semi structured interviews with eight women who had received individual cognitive-behavioural therapy in the National Health Service for their gambling problem. An Interpretative Phenomenological Analysis (IPA) approach was applied in the research process, identifying three main themes, of which the subtheme 'Barriers to Treatment' is examined here. Internal and external barriers to treatment organically emerged in all female participants' accounts, and appears to have an impact on service utilisation. Input directly from, gamblers can be combined with findings from other studies to devise better ways of reaching female problem gamblers. A better understanding of barriers to treatment can also provide valuable direction for future research and suggest applications in clinical service provision and treatment planning.

Keywords Problem gambling · Female · Treatment · Barriers · Interpretative phenomenological analysis · Cognitive-behavioural therapy

Introduction

In recent years the gambling landscape in Britain has changed significantly. The introduction of The Gambling Act 2005, which came into effect in 2007, has allowed the responsible advertising of gambling and the addition of licensed online gambling, making it possible for problem gamblers to access gaming facilities 24 hours a day. While gambling has traditionally been perceived as a male recreational activity (Potenza et al., 2001) and a male addiction, recent gambling prevalence studies indicate the gap is narrowing as a greater number of women are now gambling (Wardle et al., 2013; Wardle et al., 2011). Yet little research has focused on female problem gamblers and in particular, aspects of the treatment seeking experience for women has been neglected.

According to the latest British Gambling Prevalence Survey, commissioned by the Gambling Commission, which regulates gambling activities in the UK, there are between 360, 000 and 450,000 adult problem gamblers in Great Britain. The prevalence of male problem gambling increased from 1% in 2007 to 1.5% in 2010, while female problem gambling increased from 0.2% in 2007 to 0.3% in 2010, which translates to 75,000 women in Great Britain (Wardle et al., 2011). Interestingly the increase in overall prevalence for women was driven by younger females. The Survey also found that there has been a general increase in participation in gambling since the 2007 survey from 68% to 73%, and this increase was greater among women than men (65% in 2007 and 71% in 2010, respectively). Since gambling participation seems to be increasing faster among females than males, there may be differences in reasons for gambling requiring different treatment needs which need further examination. Furthermore services and professionals need to be prepared to treat an

[4] To be submitted to the *Journal of Gambling Studies (Impact Factor = 2.290)*

[*]✉Corresponding author: Anna Kaufman. E-mail: Anna.Kaufman.1@city.ac.uk. Address: Department of Psychology, City University London, Northampton Square, London EC1V 0HB, United Kingdom.