

Barriers to Treatment Access for Young Problem Gamblers

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Research Outputs

Findings from the programme of work presented in this thesis have been published as follows:

Rigbye, J., Buczkiewicz, M. & Griffiths, M.D. (2009) Attitudes towards gambling in adolescence: Preliminary findings. *Paper presented at the British Psychological Society Social Psychology Section Annual Conference 2009.*

Rigbye, J. & Griffiths, M.D. (2011). Problem gambling treatment within the British National Health Service. *International Journal of Mental Health and Addiction*, 9, 276-281.

All published work is included within this thesis, to be found after the appendices.

Abstract

The rate of problem gambling is more than twice as high in adolescents as it is for adults (2%) (Ipsos MORI, 2009), and the younger the age of onset of problem gambling the more severe the problem can be in later life. It has been suggested that help-seeking for gambling problems is uncommon amongst young people (Gupta & Derevensky, 2000; Haroon, Gupta & Derevensky, 2003) and a number of speculative reasons for this have been presented (Chevalier & Griffiths, 2004; Griffiths, 2001). However to date there is a paucity of empirical evidence which explore barriers to treatment access in young problem gamblers (Suurvali, 2009).

The research aims were to generate empirical evidence to identify and explain barriers to treatment access for young problem gamblers in the UK. The main objectives were to i) Explore the attitudes and perceptions that young people hold towards problem gambling; ii) Investigate the potential barriers which may prevent young people from seeking treatment; and iii) To understand the salience of the identified barriers to treatment access amongst young problem gamblers.

The research employed a mixed methods approach, incorporating exploratory studies, in-depth interviews with problem gambling treatment professionals (n=11) and problem gamblers (n=6), and a study employing Q methodology to help understand the subjectivity of opinion on barriers to help-seeking (n=21). The main findings were that there are four main groups of barriers to treatment access for young people: treatment barriers; environmental barriers; social and motivational barriers and 'gambler-centric' barriers. These barriers are experienced in different ways by different participants, and the Q methodological study identified four main viewpoints among young problem gamblers as to why they may not seek treatment.

This thesis makes an original contribution to knowledge, generating an empirical understanding of the subjective opinion on, and salience of barriers to, problem gambling help-seeking, as they are experienced by young problem gamblers, and empirically grounding previously identified barriers to treatment access in this population. A number of new barriers (emotional immaturity and poor verbal communication; lack of clinical skills in treatment providers; and lack of flexibility to suit client needs) were also identified.

Chapter One: An Overview of the Psychology of Gambling

1.1 Definition of Gambling

Gambling, the wagering of money or other belongings on chance activities or events with random or uncertain outcomes (Devereux, 1979), is something which occurs in most cultures across the world, and is generally participated in regardless of age or gender. Gambling is not restricted solely to such activities as horse and greyhound racing, or playing cards; being a 'winner' is something which is valued and celebrated amongst all cultures, and creating ways in which to win is something that has fascinated people for centuries (Reith, 1999). Devereux's definition is broad and all-encompassing, and must be broken down much further in order for us to gain an understanding of gambling and gambling behaviour. Gupta and Derevensky (1996, p.381) defined gambling as:

“using real money for a variety of types of activities, including: purchasing lottery tickets, betting on sports pools, playing cards, playing bingo, playing slot machines, betting on video games or video poker, and betting on other games of skill.”

Ladouceur et al (1999, p.57) defined gambling as:

“an activity that implies an element of risk, and that money, or something of sentimental or monetary value, could be won or lost by the participants.”

1.1.1 Types of Gambling

Numerous forms of gambling exist, ranging from betting on horses, to slot machines and casino games. In his early classification, Perkins (1950) classified gambling into four categories:

- Gaming – the exchange of money during a game (e.g. fruit machines)

- Betting – staking money on a future event (e.g. horse racing)
- Lotteries – distribution of money by lot (e.g. National Lottery)
- Speculation – gambling on stock markets (e.g. shares).

This classification has been challenged by those who disagree that speculation should be classed alongside other forms of gambling, as it is thought to be structurally different. In the UK, unlike Gaming, Betting and Lotteries, Speculation is not regulated by the Gambling Commission but rather comes under the remit of the Financial Services Authority (FSA). There are also a number of forms of gambling – sweepstakes, raffles, premium bonds – which participants themselves may disagree should be included in a classification of gambling (Cornish, 1978). It may be that as these forms of gambling hold other social functions, such as giving money to good causes or saving capital (Cornish, 1978) they are seen in a different light to betting on horses or playing cards for money. Whether simulated gambling (King et al 2012), gambling type games played online, usually on Social Networking Sites (SNS) such as Facebook, should be included in a classification of gambling is currently being investigated by a number of jurisdictions worldwide (Gambling Commission, Great Britain; South Australia). Figure 1 shows the types of gambling currently available in Great Britain, which also reflects the types of gambling investigated in the British Gambling Prevalence Survey in 2010 (Wardle et al, 2011).

Figure 1: Types of Gambling available in Britain as investigated by the British Gambling Prevalence Survey 2010.

National Lottery Draw	Online betting with a bookmaker
Scratchcards	Using a betting exchange
Another lottery (<i>e.g. charity or other lotteries</i>)	Online slot machine style games (<i>e.g. online slot machines or instant wins</i>)
Bingo in person	Fixed odds betting terminals
Bingo online	Poker in a pub tournament
Football pools	Casino table games in person
Betting on horse races	Casino games online
Betting on dog races	Other online gambling
Betting on sporting events	Spread betting
Betting on other events	Private betting with friends or colleagues
Other betting with a bookmaker	Other gambling activities

1.2 Definition of Young People

The term ‘young people’ used in this thesis is an umbrella term representing phrases including: children; teenagers; adolescents; juveniles; youth, and young adults, all of which are employed by many of the studies identified in this literature review. Whilst the term ‘young people’ has been used in the literature to relate to anyone under the age of 24 years (Valentine & Skelton, 1998), for the purposes of this study it is used to refer to those aged between 12 and 24 years. When talking specifically about those aged under 18 years, the term ‘adolescent’ is used, and when talking about those aged 16 to 24 years the term ‘young adult’ is used. The group as a whole may be referred to as youth or young people.

1.3 Gambling Participation

In Britain, the majority of adults (73%) of gambling age are likely to have gambled at least once during the previous year (Wardle, Moody, Spence et al, 2011). The National Lottery is the most popular activity with 59% of adults taking part in this activity each year. When participation in the National Lottery was excluded, 56% of adults were found to have participated in gambling during the previous year, which indicates a significant increase in participation from results found in previous prevalence surveys (46%, Sproston et al,

2000; 48%, Wardle et al, 2007). After the National Lottery, the most popular gambling activities were other lotteries (25%), scratchcards (24%), betting on horse races (16%), playing slot machines (13%) and private betting (11%). On average, individuals were likely to take part in 1.9 different gambling activities per year. It has been suggested (Holtgraves, 2009; LaPlante, Nelson, LaBrie & Shaffer, 2009) that taking part in more types of gambling is an important predictor of problem gambling.

1.3.1 Gender

Traditionally, gambling participation has had a gender divide, with more men than women taking part. Prevalence surveys have shown high rates of participation in gambling for both genders (Abbott, Volberg & Ronnberg, 2004; Wardle et al, 2007). In the most recent British Gambling Prevalence Survey, Wardle et al (2011) found that in the UK, men are more likely to gamble than women – 75% of men had gambled in the previous year, compared to 71% of women. Men were also more likely to participate in more gambling activities: males who had gambled within the past year took part in an average of three different activities per year, whereas women who had gambled in the past year took part in just over two (2.3). Women were more likely than men to play bingo and scratchcards, whereas men were more likely to gamble on slot machines, place bets on sports and make private bets with friends. It has been suggested (Grant & Kim, 2002; Ladd & Petry, 2002; Potenza et al, 2001) that men may be more likely to gamble for thrill seeking and excitement and that women may be more likely to gamble for escape or to modify adverse moods.

1.3.2 Socio-economic status

Gambling is participated in by people from all social classes, however it has been found to be more popular amongst lower socio-economic groups (Blaszczynski, Steel &

McConaghy, 1997). Past year gambling prevalence rates were highest amongst respondents whose highest educational attainment was GCSEs or equivalent (76%) or who had other qualifications (78%), those who came from lower supervisory or technical households (79%), those in paid work (78%) and those who had the highest incomes (79% for the fourth highest income quintile and 76% for the highest income quintile). It has been suggested that those classed as living in poverty perceive a greater potential to change their lives from gambling than those living in wealth (Shaffer & Korn, 2002).

1.3.3 Age

Gambling participation has been shown to be associated with age, with participation in gambling activities being lowest amongst the youngest and oldest age groups and highest amongst those aged 44-64 (Wardle et al, 2011). This may be a function of this age group having a higher amount of disposable income than either the youngest age group, who are more likely to earn less due to being in an earlier stage of their career, or the older age group who may be in retirement.

1.3.3.1 Adolescents

Measurement of the prevalence of gambling in adolescents has not been covered by the series of British Gambling Prevalence Surveys as they look at those aged 16 and over. The most recent survey to explore gambling in adolescents in Britain (Ipsos MORI 2009) found that around one in four adolescents aged between 12 and 15 had gambled in the previous week.

In terms of the types of gambling in which they participated, adolescents were most likely to play slot machines (17% had played them in the last week), place private bets for money with friends (10% past week participation), and play scratchcards (6%) or other national lottery games (6%).

1.3.4 The Recent Expansion of Gambling

There has been a huge amount of growth in gambling internationally throughout the last years of the twentieth century (Fisher & Griffiths, 1995). Authors have referred to this growth in Canada (National Council of Welfare, 1996), Australia (Productivity Commission, 1999, p.xv), and the USA (Castellani, 2000; Christiansen, 1998; Goodman, 1995; Rose, 1991; Schaffer et al, 1994). This growth can be attributed to the “unprecedented deregulation” of gambling within these jurisdictions (Fisher & Griffiths, 1995, p 239). In many European countries, such as Spain (Becona et al, 1995), Germany (Meyer, 1992) the Netherlands (Hermkens & Kok, 1991), Sweden (Ronnberg et al, 1999), France (Fisher & Griffiths, 1995), and Russia (Kassinove et al (1998), an increase in gambling activity also followed deregulation in the late twentieth century.

Interestingly, in Japan, where casinos are illegal, gambling restrictions have been bypassed with the presence of 18,000 gaming halls housing over 4 million gaming machines. Pachinko is the most common game played, with the balls needed for play being rented out to gamblers at the beginning of the session. These balls are won or lost during play and are exchanged at the end of the session for a ticket, which can then be refunded for prizes such as household items or jewellery. Often these goods are sold on to the dealers outside the gaming halls in return for cash. It is interesting to note that despite the illegality of casinos in Japan, there were more gambling machines there than in any other country in 1995 (Fisher & Griffiths).

The introduction of the National Lottery in 1994 appears to have had a profound impact upon gambling behaviour in Britain. This form of gambling was promoted as being a benign, fun activity, which due to the fact that it does not involve any element of skill, could hardly be treated as a form of gambling at all (National Heritage Committee, 1993).

In the UK, opportunities to gamble now present themselves on almost every high street (Bellringer, 1999), and with the expansion of remote gambling opportunities, people no longer need to leave their homes in order to place a bet. For the majority, gambling is a social pursuit which takes place within appropriate personal limits. These limits may be different for different individuals, for example spending within the limits of one's own disposable income, and only spending what one can afford to lose. However there are important differences between 'normal' or 'social' gambling and gambling which becomes problematic, and these are discussed below.

1.4 Pathological Gambling

1.4.1 Gambling as an Addictive Behaviour

The concept of addiction, and whether gambling can be included under the umbrella of this term, is something which has been under much debate. Many theories of addiction are based on chemical and physiological elements, rather than behavioural addiction. Davies (1992) likened gambling to a physiological addiction due to the ability of the brain to maintain its own production of addictive substances – endorphins. These are produced naturally in the brain in response to high arousal states. Therefore the suggestion is that any behaviour is potentially addictive, especially one that causes a person to feel good as a consequence. Miller & Brown (1991) suggested that because of this, boundaries of the definition of addiction are particularly difficult to establish. However, Griffiths (1995) has pointed out that many official definitions of addiction only refer to the ingestion of substances, e.g. the World Health Organisations definition is

'Addiction is a state of periodic or chronic intoxication produced by repeated consumption of a drug, natural or synthetic.' (WHO, 1957, p.46).

However, more recently definitions have broadened to include many non-drug related activities, such as over-eating, sex and gambling. Marlatt, Baer, Donovan & Kivlahan, (1988) proposed an ‘all-encompassing’ definition, stating that:

“Addictive behaviour is a repetitive habit pattern that increases the risk of disease and/or associated personal and social problems...often experienced subjectively as a loss of control’...these habit patterns are typically characterised by immediate gratification (short term reward), often coupled with delayed, deleterious effects (long term costs)...attempts to change an addictive behaviour (via treatment or by self-initiation) are typically marked by high relapse rates” (p. 224).

Brown (1993) and Griffiths (1996) have identified a number of common components of addiction. The first is *Saliency*, where the activity becomes the most important activity in the person’s life, dominating thinking via cognitive distortions and preoccupation, feelings, and a deterioration of socialised behaviour. *Conflict* arises both within the addicted person themselves and with those around them, and the addicted person builds up a *tolerance* to the behaviour, needing to increase the amount of the activity being engaged in, in order to achieve former effects. *Withdrawal* is common, which involves experiencing an unpleasant state when the addictive activity is stopped or reduced, and the effects of the activity are so powerful that engaging in the behaviour results in *mood modification* (or, according to Brown, *relief*). Finally, a tendency for relapse to occur is common, which refers to reverting to earlier forms of behaviour even after many months or years of abstinence and control.

1.4.2 Pathological Gambling – Definitions and Terms

A variety of terms have been used to describe gambling which causes difficulties for the gambler and those around him. The main terms used are “pathological gambling”,

“problem gambling” and “compulsive gambling”. ‘Compulsive gambling’ is a term frequently used by Gambler’s Anonymous which proposes ego-dystonic behaviour (behaviour which is at odds with an individual’s fundamental beliefs and principles) and does not have scope within the definition for individuals who are reluctant to cease gambling, despite the problems the behaviour causes (Moran, 1970). Other terms include, but are not limited to, addictive, dependent, excessive, impulsive, disordered and at-risk (Griffiths & Delfabbro, 2002; Griffiths, 2007). These terms are often used interchangeably to describe behaviour which encompasses an inability to control impulses to gamble which “disrupts or damages personal, family, or vocational pursuits” (American Psychiatric Association, [APA], 1994, p. 615), however in clinical practice the differing terms can have different clinical implications e.g. a ‘problem gambler’ may be advised to take a different treatment path than a ‘pathological gambler’. There is a tendency in the literature to use the term ‘problem gambling’ to either describe behaviour which, although causing problems, is at a lesser degree than the behaviours displayed by someone who meets the diagnostic criteria (e.g. Diagnostic Statistical Manual (DSM) disorder of impulse control), who would be described as a pathological gambler; or to encompass all levels of problem gambling without distinguishing between severity. This thesis will use the term ‘problem gambler’ to relate to any individual experiencing difficulty with gambling unless otherwise specified.

1.4.3 Measuring Problem Gambling

There is much debate in the literature discussing the difficulties of measuring problem gambling. This relates to issues surrounding whether prevalence rates are under- or over-reported (Derevensky et al., 2003; Derevensky & Gupta, 2006; Ladouceur 2001; Ladouceur et al, 2000), and the difficulties in comparing data (e.g., some studies focus on

past week participation (e.g., IPSOS/MORI, 2009), whereas others look at past year participation (e.g., Abbott et al., 2004)

There are a number of widely available screening tools and diagnostic criteria available for the identification and measurement of problem gambling behaviour. Diagnostic criteria are to be used by clinicians to aid judgement of whether an individual reaches the threshold for diagnosis of the condition under scrutiny. Screening tools can be used by clinicians or self-administered to determine whether a problem exists and the degree of severity and impact of the problem. Screens are usually evaluated for the ability to consistently measure key concepts. The two most commonly used examples are the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) criteria for pathological gambling, a diagnostic criteria produced by the American Psychiatric Association, (1994) and the South Oaks Gambling Screen (SOGS), a screening tool proposed by Lesieur & Blume, (1987).

1.4.3.1 DSM-IV

The DSM-IV is the fourth revision of a handbook for mental health professionals that lists different categories of mental disorder and the criteria for diagnosing them, produced by the APA. Pathological gambling was listed for the first time in 1980, in the third revision of the manual, marking the first time that pathological gambling had been officially recognised as a psychological disorder, listed under the heading ‘Disorders of Impulse Control’. The criteria have been revised under the current publication, and consist of ten criteria (see Figure 2).

There are differing viewpoints on the number of criteria that need to be met to diagnose an individual as a pathological gambler. The original cut-off value suggested was five,

however Stinchfield (2003) found that lowering the cut-off value to four made an improvement, albeit modest, to diagnostic accuracy.

Figure 2 DSM-IV (APA, 1994)

1. As gambling progressed, became more and more preoccupied with reliving past gambling experiences, studying a gambling system, planning the next gambling venture, or thinking of ways to get money.
 2. Needed to gamble with more and more money in order to achieve the desired excitement.
 3. Has repeated unsuccessful efforts to control, cut back or stop gambling.
 4. Became restless or irritable when attempting to cut down or stop gambling.
 5. Gambles as a way of escaping from problems or intolerable feeling states.
 6. After losing money gambling, would often return another day in order to get even ('chasing') one's losses.
 7. Lied to family, employer or therapist to protect and conceal the extent of involvement with gambling.
 8. Committed illegal acts such as forgery, fraud, theft or embezzlement, in order to finance gambling.
 9. Jeopardised or lost significant relationship, marriage, education, job or career because of gambling.
 10. Needed another individual to provide money to relieve a desperate financial situation produced by gambling (a 'bailout').
- Dimensions for each of the criteria are: 1. Progression 2. Preoccupation, 3. Tolerance, 4. Withdrawal and loss of control, 5. Escape, 6. Chasing, 7. Deception 8. Illegal acts, 9. Family/job disruption, and 10. Financial bailout. *Source:* Lesieur and Rosenthal, 1991.

1.4.3.2 South Oaks Gambling Screen (SOGS)

The South Oaks Gambling Screen (SOGS) was developed Lesieur and Blume (1987) in the USA as a self-rated screening instrument, and is based on the DSM-III (1980) criteria for pathological gambling. It consists of twenty questions regarding gambling behaviour, such as 'chasing losses', lying about the extent of gambling to family and friends, and feelings of guilt due to gambling behaviours.

The SOGS has been criticised due to its reliance on the DSM-III rather than on the more recent DSM-IV (Volberg et al, 1999; Walker, 1992). It has also been suggested that the

SOGS can lead to an over-estimation of problem gambling within the general population (Culleton, 1989; Dickerson, 1993; Stinchfield 2002).

1.4.3.3 Canadian Problem Gambling Index and Problem Gambling Severity Index

The Canadian Problem Gambling Index (CPGI) is a 31-item tool which was developed by Smith & Wynne (2002) who argued that by including indicators of social context and degrees of problem severity, the CPGI provides a more complete view of gambling than earlier instruments (e.g., SOGS and DSM-IV). The instrument divides gamblers into five groups: non-gambling; non-problem gambling; low risk gambling; moderate risk gambling; and problem gambling. The prevalence rates for problem gambling produced by the CPGI tend to fall between the rates produced by the DSM-IV and SOGS. The CPGI is a lengthy tool to administer, and as such is best used in assessment of a problem gambler. A shorter screen called the Problem Gambling Severity Index (PGSI) is an abbreviated version of the CPGI which consists of 9 items and can be used for self-assessment or as a screening tool (see Figure 3).

Figure 3: Problem Gambling Severity Index (PGSI)

Thinking about the last 12 months:

1. Have you bet more than you could really afford to lose?
2. Still thinking about the last 12 months, have you needed to gamble with larger amounts of money to get the same feeling of excitement?
3. When you gambled, did you go back another day to try to win back the money you lost?
4. Have you borrowed money or sold anything to get money to gamble?
5. Have you felt that you might have a problem with gambling?
6. Has gambling caused you any health problems, including stress or anxiety?
7. Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
8. Has your gambling caused any financial problems for you or your household?
9. Have you felt guilty about the way you gamble or what happens when you gamble?

*Participants answer: never (0); sometimes (1); most of the time (2); or almost always (3).
Scores are summed and the higher the score, the greater the risk that gambling is a problem for the participant:*

*0 = Non-problem gambling.
1-2 = Low level of problems with few or no identified negative consequences.
3-7 = Moderate level of problems leading to some negative consequences.
8 or more = Problem gambling with negative consequences and a possible loss of control.*

1.4.3.5 Lie-Bet Scale

The Lie-Bet Scale (Johnson et al, 1988) is a two-item used to determine whether gambling behaviour needs further investigation which asks the questions:

- 1) Have you ever had to lie to people important to you about how much you gambled?*
- 2) Have you ever felt the need to bet more and more money?*

The two items represent two criteria from the DSM-IV diagnostic criteria, selected as these items have been found to be the best predictors of problem gambling (Johnson et al, 1988).

1.4.3.6 Gamblers Anonymous 20 Questions

The Gamblers Anonymous 20 item questionnaire suggests that most compulsive gamblers will answer ‘yes’ to at least seven of their twenty items. It was developed by Gamblers Anonymous and has not been validated, and as such caution is often urged in its use.

1.4.4 Screening for Problem Gambling in Young People

Most adolescent problem gambling screens are versions which have been adapted from the adult instruments described above to be more relevant and appropriate for use with a younger population. This is achieved by modifying the questions based on the adult criteria to make them more age/developmentally appropriate (Gupta & Derevensky, 2006). Such instruments include the South Oaks Gambling Screen – Revised for Adolescents (SOGS-RA) (Winters et al, 1993); DSM-IV-J (Fisher, 1992) and its revision DSM-IV-MR-J (Fisher, 2000); and the Massachusetts Adolescent Gambling Screen (MAGS) (Shaffer et al, 1994). Common alterations made in the dimensions measured by these adolescent screens include assessing stealing money to support gambling, occupational/school-related problem and disrupted relationships. Table 1 shows the common constructs which underlie the three most commonly used instruments DSM-IV-MR-J, SOGS-RA and MAGS (Gupta & Derevensky, 2006).

Table 1: Comparative criteria found on the DSM-IV-MR-J, SOGS-RA and MAGS adolescent gambling screens (Gupta and Derevensky, 2006)

Assessment items	DSM-IV-MR-J	SOGS-RA	MAGS
Preoccupation	x		
Tolerance	x		
Withdrawal	x		
Escape	x		
Chasing losses	x	x	
Lying/secretiveness	x	x	
Loss of control	x	x	x
Illegal acts/borrowing money	x	x	x
Risked significant relationships	x		x
Bailout		x	
Family problems	x	x	x
Guilt remorse		x	x
Occupational/school problems	x	x	x
Pressure to gamble			x
Help-seeking	x		x
Frequency of gambling compared to others			x
Self-perception of gambling			x
Financial concerns			
Concern and criticism from others		x	x
Parents' gambling		x	
Amount of money gambled		x	

1.4.4.1 Canadian Adolescent Gambling Inventory (CAGI)

The CAGI (Tremblay, Wiebe, Sinchfield & Wynne, 2010) is a screening tool developed specifically for use with an adolescent population. The 44 question survey was designed to measure adolescent gambling problems, as well as the psychological and social harms, financial consequences and loss of control related to gambling behaviour. Given its recent publication there are few studies which have yet used this tool in research, however its authors report strong reliability and validity.

1.4.5 Prevalence of Problem Gambling

Prior to 2000, there was no nationally representative data from Britain outlining the prevalence of gambling behaviour and problem gambling. Rough estimates of problem gambling had been made during the 1970's (Cornish, 1978; Dickerson, 1974) however these were not representative of the population. A series of prevalence surveys have been

conducted in Britain since 2000 (Sproston et al, 2000; Wardle et al 2007; Wardle et al 2011). The two earlier studies found problem gambling prevalence rates of 0.6%, and the most recent survey found a slightly higher prevalence rate of 0.9% (Wardle et al, 2011).

The level of problem gambling in the UK is higher than that found in Sweden (0.6%) (Ronnberg, 1999), but appears to be lower than that found during prevalence studies carried out many in other countries. Most international studies have used the SOGS as a screening instrument for problem gambling (Sproston et al, 2000) therefore international comparisons are made using this measure. A meta-analysis of studies carried out in North America showed mean prevalence rates of problem gambling to be 1.1% (Productivity Commission, 1999). In New Zealand prevalence rates were found to be 1.2% (Abbott & Volberg, 1991, 1992), in Spain they were 1.4% (Becona, 1996) and in Australia they were as high as 2.3% of the population (Productivity Commission, 1999). It has been suggested that higher rates of problem gambling may be linked to increased accessibility and acceptability of gambling in these countries (Abbott & Volberg, 1992, Productivity Commission, 1999). A review of prevalence studies carried out between 2000 and 2005 (Stucki & Rihs-Middel, 2007) suggests that mean prevalence rates of problem gambling range from 1.2% (studies using the SOGS) and 2.4% (Studies using the Canadian Problem Gambling Index), however this review looked at studies using different timeframes, different methods of participant selection and sampling, and therefore it has been suggested that more comprehensive research needs to be undertaken.

1.4.6 Consequences of Problem Gambling

The negative consequences of problem gambling are different for individuals at different times, however Toce-Gerstein et al (2003) report that the consequences are different for gamblers at different levels of severity of problem gambling, with those at the lower end

reporting chasing behaviour; those with a medium level of severity reporting lying about gambling, gambling to escape and preoccupation with gambling; and problem gamblers reporting loss of control, symptoms of withdrawal, tolerance, risking their social relationships and needing to be bailed out financially. Those at the highest level of severity also reported committing crimes in order to support their gambling activity. Some of the problems associated with problem gambling include anxiety, depression, suicide, domestic violence, crime (Bland, Newman, Orn et al, 1993) as well as wider social and economic problems. It must be noted that the relationships between problem gambling and other issues are correlational, and as such no inference can be drawn about causality.

In addition to those problems described above, adolescent problem gambling is associated with major depression, anxiety, ADHD, low self-esteem, and personality disorders (Dickson, Derevensky & Gupta, 2002; Gupta & Derevensky, 2000). Young problem gamblers are also more likely to be involved in alcohol and substance abuse, theft, truancy and exhibit poor educational performance (Tacade/IGRU, 2007).

1.5 Perspectives in Problem Gambling

As gambling and problem gambling have become more widely recognised as social concerns, the literature relating to these concepts has grown, and as a result there are a number of perspectives, theories and models relating to gambling behaviour, and more specifically why people gamble. These will be discussed below.

1.5.1 Psychoanalytic Perspective

As in many areas of behavioural research, initial attempts to understand gambling behaviour were made from a psychoanalytic perspective. In essence, psychoanalysts view compulsive gambling behaviour as being caused by deep-rooted feelings of fear and

inadequacy in the gambler themselves. However, various theorists have proposed slightly differing views throughout the twentieth century.

Van Hattenberg (1914) suggested that gambling behaviour was engaged in as a form of self-punishment, in order to atone for guilt felt by a person in relation to the achievement of anal gratification during childhood. Simmel (1920) published his findings from psychoanalysis of a patient with gambling problems, furthering the work of Van Hattenberg to suggest that the desire of the gambler to expiate their guilt leads to a vicious circle of losses and gains, by which "*games of chance are a reservoir for the anal-sadistic impulses held in the state of repression*" (p353). Laforgue (1930) suggests that problem gamblers look for eroticism in fear, particularly in the fear of losing, whereas Stekel (1924) likened compulsive gambling to alcohol abuse, saying that both were induced by a need to escape and regress to childhood. Stekel also agreed with earlier theorists, that gambling was a manifestation of various repressed id impulses, such as repressed sexuality, latent homosexuality and sadism. He also suggested that gambling allowed the individual to reveal qualities which would usually be repressed, such as courage.

Sigmund Freud made psychoanalytic theory on gambling behaviour prominent through his essay on Dostoevsky in 1928. He highlighted the opinion that pathological gambling often does not appear to be motivated by financial gains, but that rather the act of gambling is the fulfilment of fantasy. He suggested that repeated gambling despite incurring losses was a means of self-punishment for feelings of ambivalence held towards a paternal figure, and that gambling is a mechanism for the unconscious reduction of guilt. Further theorists followed in the footsteps of Freud, such as Bergler (1936, 1943) whose conceptualisation of a problem gambler was as a "neurotic with an unconscious wish to lose" (Bergler, 1970, p.vii). Bergler's theory differed slightly to Freud's however, in that he relates problem

gambling with a rejection of parental rules and instead the realisation of a residual sense of childhood omnipotence. Bergler also suggested that gambling allowed the gambler to actualise fantasies of being a 'victim', drawing pleasure from defeat and punishment.

Further psychoanalysts have suggested that problem gambling is driven by a sense of being lucky, and a need to test their luck (Greenson, 1947). In line with Bergler's proposition, winning is seen as a reinforcement of childhood omnipotence. The gambler gets caught in a cycle of compulsive gambling as no amount of winning will prove his omnipotence, and no amount of losing will atone for his guilt. Galdston (1951) also suggests that gambling is an attempt to bring back a child-like state of fantasy, due in part to parental deprivation during childhood. More recent psychoanalytic theory (Rosenthal, 1987) likens problem gambling behaviour to that of alcoholics, and suggests that all addictions are in fact linked by the same psychodynamic underpinning. His research also highlights the sexual implications of gambling and the language that goes along with it.

Many of the criticisms which have been levelled at psychoanalytic theory in general also hold true for the theories outlined above. The theory is untestable, as it relates to unconscious desires and motivations which are unlikely to be known to, let alone expressed by, the gamblers experiencing them. Lesieur & Custer (1984) have in fact questioned the validity of the claim that true masochists would indeed continue with their behaviour following a winning streak or a big win. Bolen & Boyd (1968) have also highlighted that many gamblers use the activity as a way of identifying with their fathers, which does not correlate with the psychoanalytic view of gambling as a rejection of the father.

1.5.2 Biological Perspective

Although psychosocial factors are evidently involved in the aetiology of problem gambling, it has been suggested that there are certain biological factors which may predispose certain people to developing a problem with their gambling behaviour. This theory is supported by the fact that many people are exposed to psychosocial factors which may put them at increased risk for problem gambling however they manage to avoid getting into difficulty with their behaviour whilst a minority of these people experience problems (Carlton & Goldstein, 1987). This 'biopsychosocial model' has been applied to many mental health problems, including addictive behaviour, and has been an increasingly common explanation for problem gambling behaviour over the last 20 years. What actually constitutes the basis for developing problems with gambling from a biological perspective has received much attention and there are a number of competing theories which will be described below.

Physiological arousal may have an important role to play in the maintenance of problem gambling behaviour. Whilst early studies did not show a link between problem gambling rates and increased arousal levels (Rule & Fischer, 1970; Rule, Nutter and Fischer, 1971) these studies were not carried out in ecologically valid settings, and studies which have subsequently been carried out in more natural gambling environments (Griffiths, 1993; Hodgins, 2003) have shown that gambling does in fact induce increased heart rates in problem gamblers. An interesting finding in Hodgins (2003) was that the heart rates of problem gamblers were more likely to remain at an elevated level subsequent to engaging in gambling activity than non-problem gamblers. It has also been shown that pathological gamblers have higher levels of norepinephrine, a hormone and neurotransmitter which is responsible for increased levels of physiological arousal (Roy, Adinoff, Roehrich, et al 1988; Roy, DeJong, Ferraro et al, 1989). This suggests that abnormal functioning of the

noradrenergic system may be responsible for an increased susceptibility for problem gambling. Comings, Rosenthal, Lesieur et al (1994) have also indicated that low serotonin levels may be responsible for other disorders of impulse control, and this could also be true for gambling behaviour.

Evidence from twin studies can demonstrate the importance of hereditary factors in the development of problem gambling. Slutske, Zhu, Meier and Martin (2010) suggest that genetic factors account for almost half (49.2%) of the variance in problem gambling between men and women. Xian et al (2008) found that within a large sample of twins (n=1354) symptoms of problem gambling were significantly associated with cognitive distortion scores even after controlling for genetic and shared environmental influence. Orford et al (2003) suggested that there may be a neurochemical or genetic link, however described that a range of genes may be responsible for a propensity towards experiencing impulse control disorders, rather than a specific predisposition to problem gambling. Orford et al outline a need for research utilising advanced medical techniques such as Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) in order to investigate the differences in brain activity amongst problem and non-problem gamblers.

1.5.3 Behavioural Perspective

As gambling is a human behaviour, it is taken as read that it is also one which can be viewed from a learning theory perspective. A particularly salient form of learning for gambling behaviour is that of reinforcement (Skinner, 1958). Many forms of gambling (particularly fruit machines) operate on various schedules of reinforcement. Frank (1979) suggests that during the process of learning punishment is much less effective than winning, as it is a slow, gradual process of mounting loss, whereas a win is highly

effective as it has a high reinforcement effect, although different individuals will react differently in different circumstances. Knapp (1976) suggested that the act of gambling could be divided into three distinct parts: the rate of gambling, the duration of the behaviour, and persistence in that behaviour. He found that persistence in behaviour was inversely related to the density of the schedule of reinforcement – in other words the less frequently a gambler is rewarded, the more likely he is to persist in that behaviour. This is in agreement with Skinner's suggestion that intermittent reinforcement is the most effective way to maintain a particular behaviour.

The experience of a 'big win' (Moran, 1970b) has been seen as crucial to the development of problem gambling, however this has been contested by Rosecrance (1986) who suggests that it is just the opposite that can cause a gambler to begin to exhibit problematic gambling behaviour.

An interesting finding in behavioural theory is that gamblers will often display a preference for 'earning' a reinforcement, e.g. correctly completing a feature trail on a fruit machine, as opposed to a passive reward gained from repeatedly pressing a button. This may be due to experiencing an increased involvement in the game, such as watching the machine work, and the wheels spinning, may have some reinforcing quality in themselves. The illusion of control (Langer, 1975) is likely to be in place here.

Gamblers are also more likely to continue play when they are faced with a 'near miss' scenario, e.g. when 2 out of three cherries hit on a reel (Strickland & Grote, 1967), and are more likely to show a preference which gambling on machines which frequently exhibit near miss scenarios (Skaer, 1985). The mechanism involved in the near miss appears to be that it stimulates a comparable level of arousal and excitement as an actual win (Reid,

1986) and are therefore likely to reinforce gambling behaviour at little expense to the operator (Griffiths, 1991).

Another important aspect of learning theory that has been suggested to be linked with gambling behaviour is that of social modelling. One aspect of social modelling which is likely to be important is the influence a gambling parent may have on their offspring. A number of studies have shown an increased likelihood of parental gambling amongst pathological gamblers (Lesieur, Blume & Zoppa, 1986; Lesieur & Klein, 1987) and many problem gamblers report having been introduced to gambling by a parent (Lorenz, 1987). This may well be due to a lack of parental punishment for partaking in gambling behaviour.

1.5.4 Personality Theory

There has been much research which has looked at links between particular personality traits and problem gambling behaviour. This research has been generally inconsistent, and due to methodological flaws its validity has often been questioned (National Research Council, 1999). However, Blaszczynski and Steel (1998) reported a study which estimated that 93% of pathological gamblers in treatment showed evidence of having a personality disorder. Therefore it is crucial to look at the aspects of personality which may be apparent in problem gamblers. Orford (2003) suggests that due to the level of assumption that needs to be made when looking at personality research, it is difficult to be conclusive, and also reminds us that there may be aspects inherent in developing gambling problems which affect a person's personality.

Early personality research (Moravec & Munley, 1983) reported that problem gamblers score more highly on measures of achievement, exhibition, dominance, deference, heterosexuality and endurance. Such results were not repeated however by Taber, Russo,

Adkins and McCormick, (1986) who were unable to differentiate between pathological and non-pathological gamblers using the California Personality Inventory.

More focused research has highlighted certain personality traits which warrant further investigation. Zuckerman (1979) predicted that those who had a higher tendency for sensation-seeking (consisting of four factors: Seeking Thrills, Experience Seeking, Disinhibition and Boredom Susceptibility) would also be more likely to be problem gamblers. Zuckerman's hypothesis was that sensation seekers would not only derive pleasure from partaking in a risky activity, they would also experience an 'approach state' when perceiving a risky situation, and that they would derive a pleasurable sensation from this, the 'urgency elation effect'. People who are classified as sensation-seekers interestingly rate situations as less risky than do their non-sensation seeking counterparts. This interaction between anticipating less risk, enjoying the approach state and urgency elation effect that motivates sensation seekers to partake in activities deemed as more risky. This has also been identified in research by Kuley and Jacobs (1988), however other studies show no differences in sensation seeking amongst pathological and non-pathological gamblers (Ladouceur & Mayrand, 1986; Parke, Griffiths & Irwing, 2004). Some studies even show that pathological gamblers are less likely to be sensation seekers than their non-pathological gambling counterparts. These conflicting findings can be explained in part by Coventry and Brown, (1993), who suggested that certain gamblers have different motivations. Therefore a gambler who does so in order to 'escape' may be less likely to be sensation seeking than one who gambles in order to feel a 'rush' (Lesieur, 1988).

Locus of Control refers to the extent to which a person attributes events that occur in the world and in their own lives as being influenced by them or by others. An external locus

of control refers to the tendency to believe that outside influences (other people, fate, luck, God etc) are responsible for events, and conversely an internal locus of control refers to a tendency to believe that events are determined by their own behaviour. There has been much research conducted into the variation in locus of control exhibited by pathological and non-pathological gamblers, with a number of discrepancies being identified. Some studies have shown that gamblers with a higher external locus of control are more likely to develop problem gambling behaviour (Moran, 1970; Walker, 1992), whereas others (Carroll & Huxley, 1994; Dickerson, 1984) have shown the reverse. This could be explained by the differences between different gambling activities, for example those with an internal locus of control may feel that they want to have more of an influence over the outcome of the game, so may avoid games such as the Lottery or Bingo, whereas those with an external locus of control may not choose to take part in games where they have to make important decisions which influence the outcome of the bet, such as poker or blackjack. In support of this hypothesis, Carroll & Huxley (1994) found that UK fruit machine gamblers tend to have a higher internal locus of control, which would make sense given the fact that the profitability of UK machines can be affected by how the machine is played (Parke, 2007).

Other factors of personality which have been examined in relation to gambling behaviour include depression (Adkins, Krudelbach, Toohig & Rugle, 1987; Beaudoin & Cox, 1999; Graham & Lowenfeld, 1986; Vitaro, Arseneault, & Tremblay, 1999), which was shown to have a consistent correlation with problem gambling, and extraversion (Ladouceur & Mayrand, 1986; Wong, 1980) which has had mixed results. A variety of studies using the *Minnesota Multiphasic Personality Inventory* (MMPI) found pathological gamblers to score highly on a 'psychopathic deviation' scale. However, support for a 'gambling personality' has not been consistent in the literature, therefore it is difficult to rely on this

approach alone for understanding the development of problem gambling behaviour. Orford (2003) suggests that the best way to determine whether personality variables are indeed a phenomenon worthy of attention is to conduct long term longitudinal research consisting of parallel samples in terms of demographic variables.

1.5.5 Social Perspective

Theories developed by sociological researchers aim to describe behaviours as a product of social structures which exist in the world and under which each person lives. There are two main sociological theories which have been used to explain gambling behaviour and the development of problem gambling.

The first of these theories is known as the Deprivation-Compensation Hypothesis, which suggests that those who come from lower social classes are likely to experience increased pressure due to the inability to afford material goods, and are likely to feel a higher level of psychological pressure. Gambling is seen as a way of getting out of the situation that they find themselves in and is seen as a way of releasing this pressure bound on them by social class. Gambling is seen as a way of expressing their lack of fulfilment with their situation. Dereveux (1979) suggests that gambling has a cathartic function, and also argues that there is a need for gambling in society as it serves as an outlet for 'expressive needs' which are not nurtured by society. This follows on from Downes (1976) who suggested that every individual has the following needs in order to achieve 'actualisation': rationality and ethics, competition, problem-solving, thrill-seeking, and testing fate or chance. Gambling is seen as a way of addressing these needs, and in so doing, the individual is able to address the 'inertia' which may be affecting and inhibiting individuals from reaching their full potential.

The Deprivation-Compensation hypothesis is similar in many ways to Strain Theory, which attempts to explain the reasons and motivations behind deviant behaviour and crime. It was first proposed by Durkheim (1897/1966) and developed by Merton (1938), suggesting that cultural forces encourage individuals to aspire to 'greater things (wealth, status) but that society is organised in such a way that this is difficult or impossible for many. This inability to meet these expectations and aspirations in turn encourage individuals to turn to crime and deviant behaviour. Cornish (1978) cites gambling as an activity which is perceived by some individuals as being instrumental in achieving these economic and social aspirations. These theories have however received little or mild support (Downes, Davies, David & Stone, 1976; Newman, 1972; Tec, 1964).

1.5.6 Cognitive Perspective

Cognitive theories relate to the thoughts that a gambler has about his or her gambling behaviour and the impact of these on variables such as the amount of time they gamble, the stakes they wager, and the amount of money they may spend in a gambling session. These thoughts may be rational or they may be distortions of the truth, and it is hypothesised that holding cognitive distortions may be indicative of gambling problems. Langer (1975) names one such cognitive distortion as the 'illusion of control' whereby a gambler believes that he is more likely to win than probability suggests when he has more influence over the game. This has been shown to be the case in a number of studies. Strickland, Lewi & Katz (1966) found that gamblers were more likely to bet larger amounts on the throws of dice that they had control of rather than those which other people were able to throw. Similarly Henslin (1967) showed that dice players believed that they could get a more favourable outcome depending on the way in which they threw the dice, and Langer (1975) showed that people were more likely to buy a lottery ticket if they were allowed to pick their own numbers.

Wagenaar (1988) dismissed previous sociological and personality theories on the topic, and instead suggested that gamblers are motivated to gamble “by way of reasoning, not by defects of personality, education or social environment” (p30). He suggested that irrational gambling decisions were based on cognitive biases which gamblers develop and selectively use. This means that, to the gambler at least, the decisions that are made seem rational as they have been based on true thought process, but it is the underlying faulty thinking which causes inappropriate decisions to be made. Wagenaar identified sixteen different heuristics and biases and of these, the flexible attribution bias, the representativeness bias, fixation on absolute frequency and the availability bias appear to be the most prevalent. Flexible attribution is the tendency to attribute success to one’s own skill, and failure to outside influences. Those gamblers who employ the representativeness bias, also often known as the ‘Gambler’s Fallacy’, are those who adjust their gambling decisions according to statistical evaluations which are wrong. For example, a roulette ball may land on red a number of times in a row, therefore a gambler may think it more likely that the next time the ball will land on black. In actuality, the ball has just as much chance of landing on either colour as it would have had the previous results not been taken into account, yet a gambler employing the gambler’s fallacy may feel more assured of his win. A number of researchers have shown the gambler’s fallacy in action (Coups, Haddock, and Webley, 1998; Tune, 1964).

Fixation on the absolute frequency is an interesting cognitive distortion which affects those gamblers who have a high frequency of gambling activity. Because these gamblers win more than those who gamble less often or with less money, they fixate on the erroneous fact that they are making more money, They fail to take into account the fact that they are also wagering (and most often, losing) more money than the average gambler. Therefore they may be more likely to persist in gambling behaviour which is

causing them financial problems because they think that the more they bet, the more likely they are to win it back. The availability bias is employed by those gamblers who believe that if those around them win, they are likely to win too. Casinos are designed in order to promote aspects of winning play, such as metal coins bouncing on a payout tray, and music being played when someone experiences a big win, and to minimise the aspects of losing play which are arguably much more common. This gives others the impression that more people are winning than losing and encourages them to play. The same is true for the national advertisement of lottery winners. Weekly jackpot winners are often given slots in newspapers and magazines and featured on television news programmes. Seeing that other people have won may make winning seem more accessible to the gambler employing this bias, and therefore encourage them to play the lottery more often.

1.6 Models of Problem Gambling Behaviour

Various perspectives on the development and maintenance of gambling behaviour have been outlined above, however the focus of this section will now turn to describing some of the most influential models and typologies of problem gambling behaviour which have been proposed by authors in this field.

1.6.1 Jacob's General Theory of Addiction (Jacob, 1986; 1987)

Jacob's General Theory of Addiction brings much coherence to what is known about problem gambling. The underlying assumptions of this theory are that there are two conditions which serve to make a person feel uncomfortable; 1) A physiological resting state which is chronically under or over aroused, and 2) A psychological problem (or problems) such as rejection or insecurity, which create significant amount of psychological distress. Jacobs, Marston & Singer (1984) found that abusing certain behaviours (e.g. drugs, alcohol, gambling) allowed addicts to escape from physical and

psychological pain by retreating into a dissociative state. Differences in this dissociative behaviour amongst different addicted groups are noted, however this theory was supported amongst gamblers by Kuley (1986) and Jacob (1988) who found that dissociative states were much more common amongst pathological gamblers than controls. Kofoed, Morgan, Buchkoski, & Carr (1997) found that gamblers scored higher on a dissociative experience scale than alcoholic controls, with those gamblers who frequently played video lottery machines being more likely to experience more dissociative states than other gamblers. Gupta & Derevensky (1997a, 1998) undertook an empirical examination of Jacob's theory using a number of gambling behaviour screening tools amongst adolescents, and found strong support for the theory. The model they tested showed a strong path from physiological and psychological distress amongst adolescents to a need to escape and to increased severity of gambling. Gupta & Derevensky therefore suggested that gambling behaviour was in fact a coping mechanism, albeit a negative one, for adverse life conditions. In support of this, Joukhador, Maccallum & Blaszczynski (2003) have shown that whilst problem gamblers do endorse more gambling related cognitive distortions than controls, they are even more likely to believe in the power of gambling to relieve unpleasant mood states.

1.6.2 Stages of Development (Custer & Milt, 1985)

Custer & Milt (1985) proposed three stages of pathological gambling development which they described as the winning phase, the losing phase and the desperation phase. The winning phase typifies a new gambler who is exposed to higher levels of arousal feelings of higher self-esteem, and financial benefits through have a series of wins. In pathological gamblers this early phase usually contained a substantial win, one which would amount to the equivalent of one year's salary (Lesieur & Rosenthal, 1991). Custer & Milt hypothesised that this early succession of wins is likely to give gamblers a false sense of

optimism with regards to their chances of experiencing further wins. The transition between the winning and losing phase is one which signifies the beginning of a downward financial spiral in which the gambler feels that he needs to regain the money that he has lost during previous gambling sessions. The gambler may become obsessed with chasing his losses in order to escape the negative affect caused by the reduction felt in self-esteem. Gambling may become the primary social activity in an attempt to repair this self-esteem, and also as an opportunity to repair finances. Gamblers in this phase of development are more likely to see their job as a way of financing gambling, rather than as an important aspect of their lives on any other level. Money which may have been allocated for household upkeep or family commitments is often spent, and this may lead to deceit in order to hide the extent of gambling that is taking place, which in turn leads to deterioration in social relationships. Many gamblers in this phase often obtain assistance from family or friends in the form of a bailout. Whilst this is seen by the gambler as a good thing it can actually be detrimental in the long run as it removes punishment for their actions, may serve to reinforce their behaviour (Lesieur & Rosenthal, 1991) and allows them to continue in their destructive behaviour. Following further gambling, the gambler may then enter the desperation phase, and rationalises that criminal activity may be their only hope of getting out of their financial crisis (e.g. thoughts turn to theft and fraud). Many will see this as a temporary borrowing from company accounts with the intention of paying back when they hit the big win that they believe is on its way. An increasing preoccupation with chasing losses can lead to a decline in both physical and mental health. Rosenthal (1989) suggests that during the desperation phase, some gamblers may experience suicidal ideation, or consider creating a new identity in order to escape. Rosenthal added to these three phases the 'hopelessness phase', in which gamblers recognise that they unlikely to hit their big win, and that even if they do, it is unlikely to

ever make up for the amount that they have lost. This description of pathological gambling behaviour, although not allowing for differences between individuals, is useful in that it does allow us to assess the level of pathology being exhibited by a particular gambler.

1.6.3 Moran's Taxonomy (Moran, 1970)

Moran (1970) produced a qualitative taxonomy of gamblers which has received much attention in the literature. Moran realised that gamblers could not be treated as a homogenous group, and as such proposed five types of gambler. He admits that these distinctions are unclear, and suggests that they are not meant to be mutually exclusive. *Subcultural gamblers* were described as those for whom gambling was seen as the norm in their society. They feel that they are expected to gamble, as that is what everybody does in their social network. *Neurotic gamblers* were found to gamble only when placed under a stressful situation or faced with a difficult emotional problem, and gambled in order to escape. This corresponds with Jacob's General Theory of Addictions. A third subtype was labelled *Impulsive*, whose problem gambling is characterised by periods of abstinence followed by binge periods in which the gambler is entirely focused on the activity and the winning and losing of money. *Psychopathic gamblers* were described as those suffering from personality disorders such as antisocial personality, and often exhibited characteristics of impulsiveness, and finally *Symptomatic gamblers* were those who were experiencing other, primary mental health difficulties, of which gambling appeared to be an outward manifestation. Moran found specific psychometric differences between these five groups of pathological gambler, and also noted an increased prevalence of suicide across all five categories. However, Moran's sample consisted of 50 male treatment seeking gamblers and was therefore a small and biased group

1.6.4 The Pathways Model of Gambling Behaviour (Blaszczynski & Nower, 2002)

More recently Blaszczynski and Nower (2002) proposed the pathways model of gambling behaviour in an attempt to bring together biological, personality, developmental, cognitive, learning theory and ecological determinants of problem and pathological gambling behaviour. The authors suggested that to impose a rigid theory upon every problem gambler was impossible and misguided, and felt instead that different subtypes of gamblers should be acknowledged, each sharing similar phenomenological features. They proposed three pathways, each starting with availability and access to gambling, and each containing certain processes and symptomatic features in common that are distinguishable by empirically testable factors and are each subject to ecological variables, operant and classical conditioning, and cognitive processes. These three pathways account for; 1) behaviourally conditioned problem gamblers; 2) emotionally vulnerable problem gamblers, and 3) “Antisocial impulsivist” problem gamblers. This model is useful as it allows for all problem gamblers to be seen as ‘normal’ in most aspects of their lives and character, and depicts problem gambling as a transient state with fluctuations in frequency of behaviour, and where periods of remission can be observed. This model has important clinical implications as it allows for the identification of specific issues being faced by individuals to be addressed in the process to treatment through specific management strategies.

1.7 The Development of Gambling in Adolescents

Many adult problem gamblers began their gambling careers in their youth. Young people participate in gambling more so than they do in any other addictive behaviour (Gupta & Derevensky, 1998) and are likely to start participating in gambling behaviours earlier than other risky behaviours such as cigarette smoking and substance abuse (Stinchfield, 2004).

This may be due to the fact that some gambling activities (e.g. low stake/low jackpot slot machines) are legal for young people to play, whereas alcohol, controlled drugs and tobacco are illegal. However it may also be due to the fact that young people are less aware of the dangers associated with gambling. The age at which young people first participate in gambling is worrying because younger people have been shown to be at a higher risk for developing problems related to their gambling behaviour; they are often introduced to the activity by family and friends who portray it as a harmless activity (and may possibly have their own gambling addiction, Gupta & Derevensky 2000, Jacobs, 2000). The tolerance of family and friends also makes it easier for young people to gain access to gambling activities. The role of family is particularly important; Ladouceur, Boudreault, Jacques and Vitaro (1999) found that only 5% of parents would try and stop their child from partaking in gambling behaviour; whereas the vast majority of parents would prevent their child from taking drugs, and over 60% would impose restrictions on alcohol use. It has also been shown that only 2% of adolescents ever gamble alone, whereas 59% of adults always gamble alone (Valentine & Hughes, 2008). This has implications especially for explaining young people's access to restricted forms of gambling, as they may be relying on older friends or relatives as an access point to, and a means to pay for, the activity.

Adolescents typically exhibit egocentric characteristics and have a tendency towards believing in their own invincibility (Winters, Stinchfield & Kim, 1995). It has been suggested that the majority of adolescents believe that they are immune to the negative consequences of risky behaviours. Younger people are thought to have a developmental vulnerability due to the stage of their cognitive and emotional development. Piaget theorised that as young people grow up they go through various stages of development. He suggested that adolescents do not develop the ability to think critically about their

behaviour until they reach the 'formal operational stage' (Piaget, 1936), which can occur from around age 11, however many young people only reach this stage of development in their late teens, and some not at all (Siegler, 1991). Piaget's theory has been criticized often due to its small sample size and lack of empirical basis; however other research (Giedd, 2004) has shown that adolescent brain development is not complete until around the age of 25.

Often problem gamblers have had an early experience of a 'big win' (Griffiths, 1995). Adolescent problem gamblers have also been shown to hold a more positive attitude towards gambling, have poorer coping skills and exhibit more erroneous beliefs regarding luck and perceived skill (Gupta, Derevensky & Marget, 2004). However, there is a lack of longitudinal research, and no robust evidence supporting causation. Youth has also been typified as a time of general excess, as literature has identified that many adolescents experiment with risky behaviours such as the consumption of alcohol and drugs, risky sexual behaviour and risky driving. It has been suggested that adolescents may mature out of such risk taking behaviours (Chevalier & Griffiths, 2004; Griffiths, 2001). However while prevalence data suggests that many do mature out of problem gambling behaviours, over half do not follow this path (Ipsos MORI 2009, Wardle et al, 2011).

1.8 Summary and Conclusions

For the majority of individuals gambling is not harmful, because controlling the impulse to gamble is within their limits (Griffiths, 1995); although 78% of people in Great Britain gamble every year, just 0.9% of those exhibit problem gambling. However the rate of problem gambling is more than twice as high in adolescents as it is for adults (2%; Ipsos MORI, 2009), and the younger the age of onset of problem gambling the more severe the problem can be in later life. Despite increasing awareness of problem gambling, the

disorder remains largely undiagnosed and untreated because most problem gamblers do not seek treatment (Cunningham, 2005; Petry & Armento, 1999). It is vital to understand the treatment available in order to better understand why problem gamblers are reluctant to seek help. Consideration will now turn to problem gambling treatment options and help-seeking behaviour.

Chapter Two: Help-seeking and Barriers to Treatment Access

2.1 Treating Problem Gamblers

Treatment for problem gambling has been available for at least four decades (Rosecrance, 1985), however despite the longevity of the area there is a surprising lack of knowledge about what form of treatment is the most effective (Toneatto, 2006). Mental health providers who are not specialists in problem gambling also tend to be unfamiliar with its diagnosis and treatment (Petry, 1999). The lack of awareness and evidence may be due in part to a lack of research studies of different forms of treatment which can be subjected to direct comparison of outcome, or methodological flaws such as small sample sizes (Blaszczynski and Silove, 1995; Lopez-Viets and Miller, 1997; Walker, 1992) A number of reviews do however show that problem gamblers do benefit from treatment. Walker (1992) conducted a review of studies from across a number of treatment modalities (e.g. Gamblers Anonymous, psychotherapy, psychoanalysis, behaviour therapy, win therapy, case studies) and found that 72% of those completing treatment showed improvement, in that they were in control of their gambling 6 months post-treatment. The results of Walker's review must be treated with caution due to the methodological issues highlighted above; however the work is a useful source of hypotheses and a good starting point for considering issues about treatment efficacy.

The types of intervention for problem gambling include counselling, psychotherapy, cognitive-behavioural therapy, advisory services (including internet-based advice), residential care, pharmacotherapy, and multimodal treatment (combinations of treatment options) (Griffiths, 1996; Griffiths, 2005; Griffiths, Bellringer, Farrell-Roberts & Freestone, 2001; Griffiths & Delfabbro, 2001; Griffiths & MacDonald, 1999; Hayer et al, 2005).

2.2 Help-seeking Behaviour

Seeking help when experiencing problems can lead to a reduction in the negative effects of that problem. However, people suffering from psychological or psychiatric distress, even if severe, often do not seek help (Bebbington, Meltzer, Brugha, Farrell, Jenkins, Ceresa & Lewis, 2000). Encouraging help-seeking behaviour is vital for professional healthcare services, and reluctance amongst individuals to do so is one of the greatest challenges to effective prevention and treatment (Rickwood & Thomas, 2012).

Early models of illness behaviour conceptualized help-seeking as one part of the illness behaviour process (Aday & Anderson, 1975; Mechanic, 1962; Sachman, 1965). However, although it comprises one aspect of illness behaviour, it is also a dynamic process in itself. It has been described by Rickwood and Thomas (2012, p.174) as being about:

“Communicating with others to obtain assistance in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience.”

Formal help-seeking is assistance from professionals who have a recognised role in providing advice, support and treatment. Informal help-seeking is assistance from informal social networks that have a personal relationship with the help-seeker, e.g. friends and family. The term ‘treatment seeking’ has been used to delineate the difference between formal and informal help-seeking behaviour (Rickwood and Thomas, 2012).

2.2.1 Help-seeking for Mental Health Problems

The prevalence of mental health problems is not reflected in a corresponding level of service use, in fact there is a marked difference. An Australian study mapped the percentage of the population experiencing a mental disorder within a 12 month period and

the relative proportion of those who sought professional help (Slade, Johnston, Teesson et al, 2009). They found that there were pronounced differences across all age groups, however the mismatch was greatest for the age group suggested to be in greatest need, the 16 to 24 year olds, and the mismatch decreases with age. Similar patterns can be found in other jurisdictions (Mauerhofer, Berchtold, Michaud et al 2009; Zachrisson, Rodje, & Mykletun, 2006). A consistent finding has been that very few adolescents who experience distress seek appropriate help (Dubow, Lovko & Kausch, 1990; Offer, Howard, Schonert & Ostrov, 1991; Rickwood & Braithwaite, 1994; Saunders, Resnick, Hoberman & Blum, 1994; Whitaker et al, 1990). As a result, many young people do not receive adequate care (Collins, Westra, Dozois & Burns, 2004; Rickwood, Deane & Wilson, 2007).

In an Italian study, D'Avanzo, Barbato, Erzegovesi, Lampertico, Rapisarda, & Valsecchi (2012) found that while 55% of adolescents in their sample were highly likely to seek informal help, only 5% would seek formal help. Preferred sources of informal help were friends, followed by parents and partners. In a Norwegian study, only a third of over 11,000 students aged 15 to 16 who had experienced anxiety and depression reported having sought professional help for mental health issues.

Of concern is the finding that as distress increases, willingness to seek help actually decreases (Carlton & Deane, 2000; Deane, Wilson & Ciarrochi, 2001). Young men seem to be more reluctant to seek help than young women. An Australian study showed that of 3092 young adults aged 15 to 24 years, 30% of males compared with 6% of females reported that they would not seek help from anyone, and 39% of males and 22% of females would not seek help from formal services, for personal, emotional or distressing problems (Donald, Dower, Lucke & Raphael, 2000).

Adolescents are in a difficult position, in that they are often dependent on adults, but they seek independence and often don't wish for others, particularly their parents, to know about their problems (Wilson & Deane, 2012). Help-seeking often does not follow a straightforward process of experiencing distress and subsequently looking for sources of help. Of course becoming aware of a problem may be a starting point, the symptoms of mental health problems may play a smaller role than expected in prompting help-seeking (Rickwood & Braithwaite, 1994). Other factors are likely to include: identifying the problem as something to seek help for; willingness to seek help; social norms which encourage help-seeking behaviour; and access to appropriate services (Rickwood, Deane & Wilson, 2007).

2.3 Help-seeking for Problem Gambling

Rates of help-seeking amongst problem gamblers worldwide appear to be around 10-15% (Slutske, 2006). Two US national population surveys (Cunningham, 2005; Slutske, 2006) found that between 7.1% and 9.9% of lifetime problem gamblers had sought any form of treatment and/or attended Gamblers Anonymous (GA). Similar rates (10%) have been found in California (Volberg, Nysse-Carris, & Gerstein, 2006). In Australia, 23% of those with severe gambling problems and 7% of those with less severe gambling problems were found to have sought professional help or attended a GA meeting (Productivity Commission, 1999). In New Zealand, 10-15% of those with gambling problems have been estimated to seek formal help (Ministry of Health, 2007), and a Canadian population survey found that 10% of problem gamblers and 29% of pathological gamblers had sought help for their gambling problem (Suurvali, Hodgins, Toneatto, & Cunningham, 2008).

It has consistently been reported that very few young people present themselves for treatment for problem gambling (Chevalier & Griffiths, 2004; Griffiths 2001; Gupta &

Derevensky, 2000) and the rate of help-seeking in this age group appears to be lower than that of adults (Dubow, Lovko & Kausch, 1990; GamCare, 2010; Offer, Howard, Schonert & Ostrov, 1991; Rickwood & Braithwaite, 1994; Saunders, Resnick, Hoberman & Blum, 1994; Whitaker et al, 1990).

2.4 Barriers to Treatment Access

There have been a number of empirical studies that have looked at barriers to problem gambling treatment access within a general population. A range of barriers have been reported. Studies have suggested a desire among gamblers to handle their problems by themselves, or a belief in their ability to do so (Boughton & Brewster, 2002; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Nova Scotia Department of Health, 2001; Pulford, Bellringer, Abbott, Clarke, Hodgins, & Williams, 2009; Tavares, Martins, Zilberman, & el-Guebaly, 2002; Tremayne, Masterman-Smith, & McMillen, 2001). Admitting to having a gambling problem and then seeking help for that problem have been reported to be avoided due to shame, secrecy, embarrassment, pride and fear of stigma (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Rockloff & Schofield, 2004; Tavares et al, 2002; Pulford et al, 2009). Some problem gamblers may be in 'denial', described as an unwillingness to admit or a minimisation of the problems associated with gambling (ACNielsen, 2007; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Ladouceur et al., 2004; Nett & Schatzmann, 2005; Pulford et al, 2009). Many problem gamblers may express concern about what goes on in treatment or about its quality or efficacy/lack of knowledge about treatment options and practical issues around attending (Hodgins & el-Guebaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004). Problem gamblers may be affected by feeling pressure from others within their personal social networks to continue gambling, or receive a lack of support to make a change to

their behaviour (Piquette-Tomei, Dwyer, Norman, McCaslin, & Burnet 2007; Pulford et al, 2009). Some problem gamblers do not want to stop or to give up the financial, social or emotional benefits of gambling (Boughton & Brewster, 2002; Evans & Delfabbro, 2005; Tavares et al, 2002). Problem gamblers may also experience significant difficulty in sharing problems or talking about personal issues (Boughton & Brewster, 2002; Cooper, 2001, 2004; Hodgins & el-Guebaly, 2000; Rockloff & Sheffield, 2004).

2.4.1 Adolescent Barriers to Treatment Access

The literature available on barriers to treatment access for young problem gamblers is sparse and mostly speculative with only one study known to have looked specifically at young people (Ladouceur, Blaszczynski, & Pelletier, 2004.) This study asked individuals from a sample of 12-15 year olds (n=661) who had scored 21+ on the Canadian Problem Gambling Index (CPGI) and had knowledge of a peer with a gambling problem (n=7) questions about barriers to treatment access (e.g., Have your peers sought help for a gambling problem? If not why not?). They found that young people tended to minimise the harm being caused by the gambling behaviour or failed to acknowledge it as a problem. There has been no other empirical evidence published on treatment seeking by young problem gamblers, although there is some evidence to suggest that very few young people present themselves for treatment. Of all those contacting a national problem gambling charity's helpline in 2008, less than 3% were under 18 years. No-one under the age of 18 years were seen for face-to-face treatment by the charity, and of their UK-wide counselling partners, only 0.05% of those seen for counselling were under 18 years (GamCare, 2009). There is often a lower age limit for referral to certain services. However, GamCare had no such restrictions in place at that time.

Gupta and Derevensky (2000) hypothesised that given the high level of social acceptability of gambling, combined with a lack of awareness of the possible harms associated with gambling, that young adults exhibiting problem and/or pathological gambling behaviours may not actually be aware of the severity of their gambling-related problem. Haroon, Gupta and Derevensky (2003) in a study of young adults in Montreal found that those young people who were identified as serious problem gamblers (using the SOGS-RA; DSM-IV-J; and GA-20) did not often rate themselves as having any kind of serious gambling problem at all. One explanation could be that the screens are not accurately measuring gambling problems, and therefore the numbers of young problem gamblers may be overestimated. However, this explanation has previously been refuted by Gupta and Derevensky (2000) who claimed that clinical evidence suggests that the DSM-IV-J is one of the most stringent and conservative measures of youth gambling problems. They go on to further suggest that the majority of young adults do not seek treatment because they fail to recognize that they have a gambling addiction until their problems are relatively severe (e.g., legal actions pending against them, loss of friends, etc.). They note that by the time young people are willing to seek treatment for a gambling problem they are usually experiencing significant family, social, academic, and legal difficulties (Gupta & Derevensky, 2000).

A major influence on the decision to seek help for a gambling problem is reaching a financial crisis point (Abbott, 2001; Downs & Woolrich, 2009; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; McMillen et al, 2004). It may be that reaching 'rock bottom' is an important factor in seeking help, and not something that often occurs in young people due to bailout and the lack of significant amounts of money, possessions (e.g., a home) or relationships (e.g., spouse and children) to lose.

In order to encourage help-seeking behaviour and improve outcomes for young problem gamblers it is crucial to identify what may be barriers to treatment access in this population. The most comprehensive list of speculative reasons as to why young people may not seek help for a gambling problem came from Griffiths (2001; Chevalier & Griffiths 2004). This list can be sub-divided into factors that are intrinsic to the adolescent themselves, social factors, treatment availability, and problems with research methods and screening tools.

2.4.1.1 Intrinsic Barriers

- *Denial*: Adolescents with a gambling problem may fail or refuse to acknowledge the problem;
- *Not wanting to seek treatment*: Some adolescents may know that they have a gambling problem but may choose not to seek treatment for it;
- *Occurrence of spontaneous remission/maturing out*: It may be that some young people 'grow out' of their gambling problem without outside help;
- *May commit suicide first*: Some adolescents may commit suicide because of a gambling problem before they are able to seek treatment;
- *Adolescent excesses change too frequently to warrant treatment*: Youth is a time of general excess and those excesses may change too quickly to warrant treatment;
- *Adolescents don't seek treatment in general*: Young people may be reluctant to seek treatment for any problem, not just gambling problems;
- *Adolescents may seek another form of treatment before getting treatment for gambling*: Young people may be more likely to seek help for other problems such as depression before seeking help for problem gambling; furthermore treatment for another problem may concurrently help the gambling problem;

- *Treating underlying problems may indirectly help gambling:* It may be that young people are more likely to seek treatment for an underlying problem, such as depression, that indirectly helps their gambling problem;
- *Negative consequences not unique to gambling:* As the negative consequences of a number of adolescent behaviours may be the same as those caused by gambling, and this may mean that gambling is not treated as an underlying factor in problem behaviour.

2.4.1.2 Social Barriers

- *Parental bailout:* Turner and Lieu (1999) showed that young people are most likely to seek treatment when the consequences of their behaviour are most severe, particularly in relation to finances. Therefore, if their parents are bailing them out financially they may be less likely to seek help;
- *Bailouts can mask the problem:* it may be that parental bailout helps to cover the problem repeatedly throughout adolescence, but that bailout is less likely to occur when they are older, which may explain the high number of adults seeking treatment reporting that they have had gambling problems since adolescence.
- *Socially constructed to be non-problematic:* In youth, problem gambling may be deemed socially acceptable if it is highly prevalent within peer groups and/or the family.

2.4.1.3 Research and Screening Tool Barriers

- *Lying or distortion on self-report measures:* Young gamblers may lie or exaggerate when completing surveys (Stinchfield, 1999);
- *Possibility of invalid screening instruments for measuring problem adolescent gambling specifically:* It may be that the screens used for measuring problem

gambling in young people under or over estimate the number of problem gamblers in this age group. This may have an impact on the perception of treatment seeking behaviour which may in fact be higher or lower than currently presumed;

- *May not understand what being asked:* Ladouceur, Bouchard, Rhéaume, Jacques, Ferland, Leblond and Walker (2000) noted that only 31% of students in their sample correctly understood all of the items in the SOGS-RA;
- *Screening instruments being used incorrectly:* Stinchfield (1999) highlighted that there has often been lenient use of the diagnostic criteria cut off points for youth gambling problems in some studies;
- *Some researchers may be exaggerating adolescents gambling problems to serve own career needs:* Chevalier & Griffiths (2004) suggested that an explanation for high rates of problem gambling found amongst young people may be that researchers who rely on funding in this area may overstate these rates for personal or institutional gain.

2.4.1.4 Treatment Barriers

- *Lack of adolescent treatment programmes;* It may be that the lack of availability of treatment services for young people is reflected in rates of help-seeking;
- *Treatment programmes not being appropriate/suitable for adolescents;* The treatment programmes which are available may not offer services for younger clients;
- *Attending treatment programs may be stigmatising:* For example, seeking treatment may draw attention to their 'failure', and may mean they can no longer participate in the activities by which they and their group define themselves.

While Chevalier & Griffiths (2004) acknowledge that some of these speculations are not grounded in empirical evidence (i.e. denial of the problem by adolescents, adolescents not wanting to seek treatment, researchers exaggerating the problem), they are nonetheless vital as a starting point for developing our empirical understanding of barriers to treatment access for adolescents.

The Gambling Act 2005 had as one of its central tenets the aim of ‘protecting children and other vulnerable person’s from being harmed or exploited by gambling’ (Part 1). As such, there needs to be more focused research into treatment and prevention of gambling problems in order to continue to develop the UK’s approach to protecting young people. As the evidence suggests that very few young people are accessing treatment for gambling problems, it is important to understand why this is so that services can improve the treatments they offer to make them more accessible to young people.

2.5 Aim of Research

The rate of treatment seeking for young problem gamblers is particularly low, given the prevalence rate of the problem (2%, Ipsos MORI, 2009) in this age group is over twice as high as that found in adults (0.9%, Wardle, 2011). Although the low rate of treatment seeking is not necessarily surprising given what we know about help-seeking behaviour in general, and specifically amongst young people and problem gamblers, further exploration of this area would be beneficial in order to understand the barriers to seeking treatment and how to overcome them.

Therefore, the main aim of the research presented in this thesis is to fill the gap in our knowledge using empirical evidence to identify and explain barriers to treatment access for young problem gamblers in the UK. The research aimed to use a mixed methods approach, incorporating initial exploratory studies, in-depth interviews with problem

gambling treatment professionals and problem gamblers themselves, and a study employing Q methodology to help understand the subjectivity of opinion on barriers to help-seeking.

The main objectives were to:

- 1) Explore the attitudes and perceptions that young people hold towards problem gambling;
- 2) Investigate the potential barriers which may prevent young people from seeking treatment;
- 3) To understand the salience of the identified barriers to treatment access amongst young problem gamblers.

The objective of this thesis was to address these aims through a series of linked research stages, to advance understanding in this area and to generate findings that will guide treatment providers, policy makers and the gaming industry in their practises in relation to this age group.

Chapter Three: Methodology

3.1 Chapter Overview

The aims of this thesis are to explore the attitudes and perceptions that young people hold towards problem gambling; to investigate the potential barriers which may prevent young people from seeking treatment; and to understand the salience of the identified barriers to treatment access amongst young problem gamblers. A mixed method approach has been adopted. This chapter will examine the application of the mixed method approach: the epistemological assumptions behind the research will be explored and a critical analysis of the processes of data collection and analysis used during this thesis will be defined.

3.2 The Mixed-Method Approach

The debate around the application of quantitative or qualitative methodologies has continued for a number of decades, and has evolved from discussing the incompatibility of the techniques and procedures to debating the incompatibility of the epistemological assumptions of quantitative and qualitative “paradigms” (Howe, 1992). Essentially, quantitative research aims to describe psychological constructs according to a numerical system, whereas qualitative research is often defined only by not being quantitative, e.g. using approaches which do not involve statistics or does not rely on the objectivity that supports a quantitative approach (McQueen & Knussen, 2006). Qualitative research is concerned with the experiences and meaning within rich data such as that obtained from text, images or sound.

The aims of this thesis may at first appear to lend themselves to qualitative research, as they are concerned with exploring awareness, experience and attitude, rather than closed-ended, quantifiable data. However, while a qualitative approach may be preferred, adding

a quantitative element to research is likely to allow the formation of a more complete picture, by either corroborating qualitative data or by providing a broader insight into trends and generalisations, in addition to the in-depth knowledge gained through qualitative investigation. A ‘mixed-methods’ approach (Tashakkori & Teddlie, 2003a) combines both quantitative and qualitative research. Mixed methods research has been referred to using differing terminology since its inception: for example ‘multitrait/multimethod research’ (Campbell & Fiske, 1959); ‘integrated’ or ‘combined’ research (Steckler, McLeroy, Goodman, Bird & McCormick, 1992), ‘hybrids’ (Ragin, Nagel & White, 2004); and ‘methodological triangulation’ (Morse, 1991). Cresswell and Plano Clark (2007) define mixed methods research as follows:

“A research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and then mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone”

(Cresswell & Plano Clark, 2007, p5.)

This definition is unique to other definitions of mixed methods research (e.g. Cresswell, 1994; Ragin, Nagel, & White, 2004; Tashakorri and Teddlie, 1998) because it includes the ‘mixing’ of datasets. Cresswell & Plano Clark emphasise that it is not enough just to collect and analyze both quantitative and qualitative research as part of a research

programme, but that it is vital to mix the data to provide a better understanding of the problem than if each dataset had been used by itself.

While Cresswell & Plano Clark's definition is somewhat long and elaborate, it is useful because it identifies both the epistemological and methodological difficulties inherent in the conceptualisation of such research. This chapter aims to discuss and resolve these issues, while giving an explanation for the methodologies chosen to address the research aims.

3.2.1 Philosophical Assumptions

It is of vital importance before designing any study that the philosophical assumptions underlying the research are specified. Every researcher brings to their work their own paradigm, or view of the world, which affects how they go about their research. A paradigm contains a set of core beliefs or assumptions that guide research (Guba & Lincoln, 2005). While these paradigms may be fluid and alter within a person over time, it is critical to identify how they may affect one's research prior to conducting any enquiry to legitimise the research, and researchers therefore need to be reflective and aware of their own paradigms.

All paradigms have common elements, but take different views on each element. Figure 4 outlines the elements which make four paradigms often used in research.

Figure 4: Four paradigms used in research

Postpositivism	Constructivism	Advocacy and Participatory	Pragmatism
Determination	Understanding	Political	Consequences of actions
Reductionism	Multiple participant meanings	Empowerment and issue oriented	Problem centred
Empirical observation and measurement	Social and historical construction	Collaborative	Pluralistic
Theory verification	Theory generation	Change oriented	Real-world practice oriented

Pragmatism has been conveyed as the most appropriate philosophical paradigm for mixed methods research. The focus of pragmatism is on the consequences of research, and regards the question being asked as the issue of primary importance, rather than the methodology used to address it. Multiple methods of research can inform the problem being studied, and as such pragmatism is pluralistic. A pragmatic approach may combine both inductive and deductive thinking, as the researcher mixes both quantitative and qualitative data.

3.2.2 History of Mixed Methods Research

Giving a brief historical overview of mixed method research is intended to examine the philosophical foundations of such a design, describe the conflict and debate within the literature about such research and defend the choice of such methodology in answering the aims of this thesis.

During the 1950's initial interest developed in using more than one method of research within a study, with Campbell & Fiske (1959) suggesting that multiple forms of quantitative data should be collected in order to validate research into 'traits' in psychology (developing the multitrait/ multimethod matrix). Researchers combined both

quantitative and qualitative data in the 1970's (Jick, 1979; Sieber, 1973). Philosophically, it was asserted that different assumptions provided the foundations for quantitative and qualitative research (Guba & Lincoln, 1988; Smith, 1983) and therefore it was argued that mixing such methods was untenable. This was challenged however by Bryman (1988) who suggested that there was a clear connection between quantitative and qualitative research, and this argument is further backed by Rossman and Wilson (1985) who trichotomised researchers into 'purists', those who would not mix paradigms, 'situationalists', who would adapt their methods to suit the particular research situation, and 'pragmatists' who suggested that multiple paradigms were useful in addressing research problems. Pragmatism has been suggested by many recent advocates of mixed methods research (Cresswell & Plano Clark, 2007; Tashakorri & Teddlie, 2003). Greene and Caracelli (1997) call for researchers to utilise mixed methods but be sure to be explicit about which paradigms and assumptions are being used at each stage. Greene & McClintock (1985) highlight the need for a clear definition of the purpose of mixing qualitative and quantitative designs.

Mixed methods designs are becoming more commonly utilised in published literature. Plano Clark (2005) found more than 60 mixed methods articles published in the social and human sciences between 1995 and 2005. Since the turn of this century there has been a proliferation of published research utilising mixed methods design in a number of disciplines, including Medicine (Cresswell, Fetters & Ivankova, 2004), Counselling Psychology (Hanson, Cresswell, Plano Clark, Petska & Cresswell 2005), and Education (Johnson & Onwuegbuzie, 2004). The most telling occurrence in the brief history of mixed methods research is the launch of the 'Journal of Mixed Methods Research' in 2007, establishing the importance of the methodology in academia. Whilst mixed methods has more commonly been used to describe the mixing of both qualitative and quantitative

data within a single study, it has also been used to describe programmes of enquiry which are reported as separate studies and use solely quantitative or qualitative methods in each, but form an overall large scale mixed methods research programme. This is the approach used in the programme of research presented in this thesis.

3.2.3 Type of Mixed Methods Design

There exist a vast array of classifications of types of mixed methods design such as that proposed by Greene, Caracelli & Graham (1989); Tashakkori &

Teddlie (2003) identified over forty designs within the literature. Greene, Caracelli & Graham (1989) conducted an analysis of the mixed methods employed in 57 evaluative research projects, and developed a conceptual framework for mixed method design which aimed to include all types of mixed method designs included in the analysis. This framework encompassed five purposes for mixed method design implementation: triangulation, complementarity, development, initiation and expansion. (see Figure 5). The authors suggest that a common misperception is that mixed-method designs should be used for triangulation of data, however they propose that the concept of triangulation has become unclear and suggest that a reliance on this purpose may cause researchers to give less thought to implementing mixed-method research for other purposes.

Figure 5: Purposes for mixed method designs (p259 Greene, Caracelli and Graham, 1989)

Purpose	Rationale	Key theoretical sources
<i>TRIANGULATION</i> seeks convergence, corroboration, correspondence of results from the different methods.	To increase the validity of constructs and inquiry results by counteracting or maximising the heterogeneity of irrelevant sources of variance attributable especially to inherent method bias but also to inquirer bias, bias of substantive theory, biases of inquiry context.	Campbell & Fiske, 1959 Cook, 1985 Denzin, 1978 Shotland & Mark, 1987 Webb et al. 1966
<i>COMPLEMENTARITY</i> seeks elaboration, enhancement, illustration, clarification of the results from one method with the results from another method.	To increase the interpretability, meaningfulness, and validity of constructs and inquiry results by both capitalizing on inherent method strengths and counteracting inherent biases in methods and other sources.	Greene, 1987 Greene & McClintock, 1985 Mark & Shotland, 1987 Rossmann & Wilson, 1985
<i>DEVELOPMENT</i> seeks to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions.	To increase the validity of constructs and inquiry results by capitalizing on inherent method strengths.	Madey, 1982 Sieber, 1973
<i>INITIATION</i> seeks the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from another method.	To increase the breadth and depth of inquiry results and interpretations by analyzing them from the different perspectives of different methods and paradigms.	Kidder & Fine, 1987 Rossmann & Wilson, 1985
<i>EXPANSION</i> seeks to extend the breadth and range of inquiry by using different methods for different inquiry components.	To increase the scope of inquiry by selecting the methods most appropriate for multiple inquiry components.	Madey, 1982 Mark & Shotland, 1987 Sieber, 1973

Upon review of the forty mixed method designs identified by Tashakkori & Teddlie (2003), Cresswell & Plano Clark (2007) noted that although these designs derive from a variety of academic disciplines and research purposes, and lack consistency in naming, it is possible to identify a number of similarities between these classifications. As such they proposed four major mixed methods design which can be employed across disciplines.

3.2.3.1 Triangulation Design

Data is collected using both quantitative and qualitative methods, ensuring that the strengths of one method can attenuate the weaknesses in another. For example, whereas a quantitative study may allow for large sample sizes, allow for the identification of trends in the data, and may allow for the generalisation from data to a given population, qualitative data on the same subject may provide a small sample size but give more detailed and in depth data on the same subject (Patton, 1990).

Triangulation has a number of strengths which make it attractive to the researcher. It is well covered in the literature, and was in fact the first mixed method design to be discussed (Jick, 1979) so there is an existing framework under which to begin research. It is efficient, as it allows for the concurrent collection of data, and lends itself to team research and for specialists in either qualitative or quantitative methods to work on the same program of research. However, there are certain challenges, such as the need for a lone researcher to develop a breadth of knowledge in order to successfully carry out both quantitative and qualitative research. The researcher will also need to consider the consequences of having different samples and sample sizes if converging multiple datasets and consider weighting cases, which can be challenge to conduct in a meaningful way.

3.2.3.2 Embedded Design

One dataset provides a supportive role in a study based on a different data type, for instance collecting qualitative data to follow up on the results of an experiment which resulted in quantitative data. In such a design quantitative and qualitative methods are used to answer separate questions within a research study; however it is identified as an embedded design as the major dataset would make sense reported as a study in its own right, whereas the supportive dataset would not stand alone.

An embedded design is popular when there are time or resource constraints, and may make a study more logistically manageable. However researchers need to be careful to consider the timing of the two phases of data collection to avoid any potential bias. It can be difficult to integrate the two research designs within a study, although the aim is not to triangulate, or use the data to answer the same question, therefore the results from each method of data collection can be reported sequentially or even separately.

3.2.3.3 Explanatory Design

The researcher uses qualitative data to build upon or to explain the results found from a quantitative study (Cresswell, Plano Clark et al. 2003). This can also be used where the researcher wants to use purposive sampling of participants for a qualitative study from based on the results of a quantitative phase of research.

An explanatory design is described as one of the most straightforward methods of mixed methods research, as it is conducted in two phases at two separate times, and therefore allows the collection of different types of data to be the main focus at any one time. However the sequential nature of the design requires a longer period of time in which to complete the study.

3.3.3.4 Exploratory Design

The researcher develops a quantitative study from the results explored by a qualitative study (Cresswell, Plano Clark et al. 2003). The design begins qualitatively in order to explore a phenomenon which has not been thoroughly explored before and the qualitative aspect of the research allows for the generation of or identification of variable to study using quantitative methods. Due to the similarities of the explanatory and exploratory designs, both types of design have the same strengths and weaknesses in terms of allowing each type of data to be the main focus at any one time, but incurring related time requirements.

The cross disciplinary aspect to Cresswell & Plano Clark's classification is an important one, as many other classification systems rely on methods employed in one field of research alone.

3.2.4 Mixed Methods Design – A Summary

Mixed methods research is an emerging methodology, with a sound philosophical foundation. It is quite distinct from qualitative research, and choosing an appropriate and rigorous design for mixing methods is key to its acceptance as a valid research approach. Though it requires both qualitative and quantitative skills, if the researcher has the time and resources necessary to conduct careful research, a mixed method design may be best suited for addressing a complex research question.

3.3 Study Outlines

The studies conducted to inform the aims of this thesis constitute an explanatory mixed method approach, utilising a range of methodological procedures for data collection and analysis. Studies one and two employed exploratory questionnaires to gather data with the aim of setting the research context, describing treatment availability for problem gambling

through the NHS, and presenting a secondary analysis of an existing dataset to explore adolescent attitudes to gambling and perceptions of gambling related harm. Studies 3a and 3b employed in-depth interviews and thematic analysis to explore the perspectives of both problem gambling treatment specialists and young problem gamblers respectively. Study 4 employed Q methodology to draw together the findings from both published literature and the previous studies within this thesis to explore subjectivity of opinion barriers to treatment access for young people. Each study is presented in subsequent chapters; however the methodological procedures used in each are explored in more detail in the subsequent sections of this chapter.

3.3.1 Study 1: Treatment Provision in the NHS

This study aimed to assess what services were currently being provided within the NHS for those with gambling problems, in order to provide context for the research programme investigating barriers to treatment access for young people with gambling problems in the UK. The study employed a questionnaire design, and is described in detail in Chapter Four.

3.3.1.1 Questionnaire Design

Questionnaires are useful for gathering exploratory data, particularly when they allow open ended responses. While this information could also be gathered using interviews or focus groups, using a questionnaire allows the researcher to get a feel for the range of likely responses, and to discover how common these responses may be. They also allow for the accurate accumulation of demographic data in addition to any open ended responses, enabling more detailed statistical analyses to be carried out.

Questionnaires are a cost effective method of data collection, particularly when the researcher's presence is not necessary for the questionnaires to be filled in. (Bachrack and

Scoble, 1967; Benson, 1946; Hochstim and Athanasopoulos, 1970; Moser and Kalton, 1971; Seitz, 1944). It is possible to obtain responses from a wide geographical area, giving greater potential for generalisability from the results (Clausen and Ford, 1947; Goode and Hatt, 1962; Ruckmick, 1930). It is also a relatively quick method of data collection, as arrangements do not always need to be made for the researcher to be in attendance while each questionnaire is being filled out therefore large amounts of data can be gathered in a short period of time. Questionnaires are generally familiar to most people, and therefore explanation other than written instructions specific to the questionnaire are unlikely to be necessary (Berdie, Anderson, and Niebuhr, 1986). However, if the researcher is not present, difficulties that may be encountered include non-response and potential misinterpretation of the requirements of the questionnaire. Misinterpretation can hopefully be avoided by robust questionnaire design.

In terms of the type of data collected by questionnaire methodology, it is possible for more sensitive issues to be addressed than if the data was collected via face-to-face interviews or focus groups, as the data can be entirely anonymous. This is particularly true with young people who are anecdotally less likely to express their true opinions in a face-to-face setting where they may fear giving the 'wrong' answer, or due to the effect of social facilitation, whereby the respondent wants to be liked by the researcher and therefore responds in such a way that reflects what they think the research would like to hear.

Open ended questions allow the respondent to write as much or as little as they choose in response to a question. The advantage of this over closed-ended questions is that it allows for exploratory data to be collected. If eliciting closed-ended responses, the researcher would have to have a reasonable idea of likely responses to the questions prior to the administration of the questionnaire, and allow the respondent to choose from a list of these

responses. Closed-ended questioning assumes that respondents share the same understanding of the questionnaire items and response categories as the researcher. This may be advantageous in some studies as the categories available clarify the type of response necessary, as well as reducing the number of ambiguous responses and coding errors. However, it is much better suited to hypothesis-testing research, rather than exploratory data collection. In exploratory research, open-ended questioning allows for unexpected responses and does not create artificial forced choices. Respondents have the freedom to respond however they see fit without being influenced by the responses suggested for them, allowing for the collection of richer and perhaps more valid data.

One problem with sending out questionnaires for unsupervised return is that they may not be completed and returned by the person for whom the questionnaire was intended (Clausen and Ford, 1947; Franzen and Lazarsfeld, 1945; Moser and Kalton, 1971; Scott, 1961). Even if the questionnaire is completed by the intended recipient, the responses may be subject to the limitation of self-report methodology such as social desirability biases, negative affectivity bias, and acquiescence, which is a tendency to endorse all statements, even if they may be contradictory (Edwards, 1953, Lanyon & Goodstein, 1997).

Coding data from open-ended questionnaires involves sifting detailed information into a discrete number of categories in order to enable a simple description of the data and allow for statistical analysis. Open-ended questionnaire responses may be difficult to code. While it is possible to manipulate the data into numerical format and subsequently subject the data to statistical analysis, this has to be done with caution, particularly when dealing with a large datasets. One of the main difficulties that may be encountered is that coding is (to some extent) subjective, so one researcher may be likely to get different results from data coding than another, and that the coding may change over time so that what the

researcher coded in one category early in the coding process, they may code differently later in the process. This can be avoided by maintaining a coding log, which includes the code given to a type of response along with a note as to why the response was coded as it was. This log can then be referred back to as the coding progresses to ensure that the correct coding is being used. It is also useful to only have one researcher who is responsible for the coding of the data, eliminating researcher bias.

3.3.2 Study 2: Adolescent Attitudes to Problem Gambling

Permission was sought to undertake a secondary analysis of a large dataset available to the International Gaming Research Unit at the Nottingham Trent University. This dataset had been created as part of a research project aimed at informing the development of educational materials for use with adolescents in educational settings. The dataset had not been previously subject to any statistical analysis, and as such data were recoded and subjected to a series of statistical analyses to explore the impact of age and gender on attitudes to and understanding of gambling and problem gambling. The results of this study are presented in Chapter Five.

3.3.2.1 Method of Analysis: Chi Square and T-tests.

The original survey was designed to elicit open ended responses from children, e.g. asking them to write down words which came in to their head when they thought about a concept (e.g. gambling). The only demographic data collected was age and gender. Responses were coded into categorical variables in SPSS, and the data was subjected to independent samples t-tests to identify age effects, and chi square to identify gender effects. T-test analysis allows the assessment of whether the means of two groups are statistically different from one another. Chi Square analysis allows us to compare our observed data with the expected variance within the data.

3.3.3 Studies 3a and 3b: In-depth Interviews with Problem Gambling Treatment Providers and Young Problem Gamblers.

Study 3a aimed to investigate the perspectives of problem gambling treatment providers on the potential barriers to treatment access for young problem gamblers. Study 3b explored the same issue but with a sample of young problem gamblers themselves. These studies both employed in-depth interviews, the data from which was analysed using Thematic Analysis, and as such the procedure and analysis are described together below. Studies 3a and 3b are described in detail in Chapter Six.

3.3.3.1 In-Depth Interviews

Interview methodologies have a number of advantages over other forms of data collection, particularly when exploring ideas and concepts as part of a wider research programme. Semi structured questionnaires often detail a number of topics to be covered with some specific questions, however where the aim is to elicit detail based on the respondents experience, there needs to be flexibility in schedule design.

Interview methodologies have a number of weaknesses that may affect the validity and reliability of the data gathered. However, these are not necessarily specific to the interview approach, as they are also apparent in other methods. Interviewing is essentially a self-report methodology, and therefore the data gathered is subject to the ability of the individual to provide accurate and complete information about the topic they are discussing with the interviewer. However, respondents may lie particularly when discussing sensitive topics. This may be due to wanting to avoid embarrassment. The characteristics of the researcher may lead to the ‘researcher effect’ or ‘experimenter effect’. This supposes that a researcher’s gender, age, personality, dress, or manner may affect the respondent’s readiness or capacity to provide accurate and complete accounts of events. It may also be that characteristics of the respondent may affect the way in which

the interviewer poses questions (Edwards, 1953, Lanyon & Goodstein, 1997). There are a number of ways to control for this. The interviewer could ensure that their manner of dress is always the same and take steps to control other variables such as the language and tone of the interview. A pool of interviewers could be randomly allocated to undertake a number of interviews each, meaning that any strong effects caused by one particular interviewer could be eliminated. However this is only practical in large scale research programmes. A lone interviewer must therefore be reflective and aware of their own prejudices that may be relevant to the research topic. This could be achieved through supervisory debriefing.

It may be that details are remembered inaccurately and therefore the respondent may inadvertently give false information. One way to control for this type of error in data collection is to construct questions in order to access the same information in different ways, allowing for a simple check of internal consistency to be carried out. If the respondent seems unsure of details, these can be clarified through further questioning, or the data may be excluded from the analysis if it is deemed to be a significant problem. Clearly consistency in data does not reflect accuracy, but it is still worthwhile building in some checks on consistency to the interview schedule as inconsistency certainly imposes inaccuracy.

3.3.3.2 Thematic Analysis

Thematic analysis is a way of recognising, analysing and describing patterns, or ‘themes’, within qualitative data, providing rich and minimally organised information. A theme gives information that is relevant to the research question. Thematic analysis is seen by many as a foundation upon which researchers can build their knowledge of qualitative research methods (Braun & Clarke, 2006; Holloway & Todres, 2003) as it uses core skills

useful for many other forms of analysis. In fact, some researchers propose that thematic analysis should not be regarded as a method in its own right, but rather as a tool for use in other methods of analysis (Boyatzis, 1998; Ryan & Bernard, 2000). This point of view stems from the fact that codifying data is carried out in a number of other methodologies, such as grounded theory and interpretative phenomenological analysis. However, Braun and Clarke (2006) argue that qualitative analysis can be divided into two main ‘camps’; the first encompassing methods which are bound with a certain epistemological position, such as grounded theory; the second which remains independent of epistemology and can be applied across a range of theoretical approaches. According to Braun and Clarke, thematic analysis belongs in the second category as it has relative theoretical freedom.

However, theoretical freedom brings with it a lack of succinct guidelines as to how to carry out thematic analysis, and it has been suggested that thematic analysis lacks clear definition in research (Boyatzis, 1998; Rolton, 2001). In order to combat this it has been proposed that researchers using thematic analysis should make explicit their theoretical and epistemological assumptions that informed the analysis, with the aim of explaining ‘how’ they undertook their analysis, which is often overlooked (Attride-Stirling, 2001; Holloway & Todres, 2003).

Thematic analysis is a flexible method of research which allows for the generation of unexpected insights from the data. However, increased flexibility indicates that the range of things that can be derived from the data may be broad. This may potentially make it difficult for the researcher to focus on what is important to draw out from the data. This is where supervision in research becomes important, as this will allow the researcher to take a step back from the data and regain perspective in order to understand which issues most relevant for the research aims in hand.

Thematic analysis is quick to learn and do (Braun & Clarke, 2006), allowing the researcher to collect and analyse a relatively large amount of data. The resulting information allows minimally organised yet rich results that are accessible to an educated audience with no prior experience of the method. Importantly, this method of analysis also allows the researcher to highlight similarities and differences across the dataset, which is important in this research as it allows for the data gathered from a variety of stakeholders to be usefully compared, which will be crucial in identifying potential barriers for access to treatment for young problem gamblers.

One major disadvantage of thematic analysis is that it holds limited interpretative power. The analysis is limited to describing the data rather than making inferences from it as to 'how' or 'why'. Another disadvantage of using thematic analysis is that, generally, it does not hold a high reputation amongst many researchers, mainly due to the lack of reporting of how the analysis has been carried out (e.g. Braun & Wilkinson, 2003) or the epistemological assumptions that underpin it. If this information is not reported, it is difficult to evaluate the method, or to compare it with other data in the field (Attride-Stirling, 2001). Therefore this thesis employs the method of thematic analysis suggested by Braun & Clarke, (2006).

Phase One: "Familiarise yourself with the data": It is vital that the researcher immerses themselves in the data, which usually involves active repeated reading during which meaning and patterns are searched for. Notes should be made for coding that will be revisited in subsequent phases. Verbal data must be transcribed verbatim, which is a useful way of familiarising with the data (Riessman, 1993) and has been suggested as a key phase of analysis in itself (Bird, 2005).

Phase Two: “Generating Initial Codes”. Codes identify a feature of the data which appears interesting to the analyst. Codes refer to:

“the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon”

Boyatzis, (1998, p63)

Coding allows data to be sorting into meaningful groups (Tuckett, 2005) and is part of the analysis (Miles & Huberman, 1994). However the themes which emerge are much broader than the individual codes, and in data driven (rather than theory driven) research will depend on the data itself.

Phase Three: “Searching for themes”. This phase refocuses analysis at the broader level of themes and involves sorting codes into particular themes. Relationships between and within themes and the levels of themes (e.g. where they may be placed in a hierarchy) should be considered during this phase.

Phase Four: “Reviewing Themes”. Once a set of candidate themes have been devised, the researcher must then refine them. During this phase themes may be collapsed if there is not enough data to support them or expanded if the data are too diverse.

Phase Five: “Defining and Naming Themes”. In this phase the researcher must identify the essence of each theme, ensuring it is not too diverse or complex, and organise data extracts into a coherent and internally consistent account with an accompanying narrative. The themes must not have too much overlap. Sub-themes must at this stage be identified, which can be useful for structuring and giving hierarchy to the theme.

Phase Six: “Producing the report”. The final phase of thematic analysis entails the telling of a story about the data in such a way that convinces the reader of the merit and validity of the research. The analytic narrative must also make an argument in relation to the research question.

3.3.4 Study 4: Subjective Experiences of Barriers to Treatment Access for Young Problem Gamblers

Study 4 is the final study in this thesis, the aim of which is to employ Q methodology to explore the subjective viewpoints of young problem gamblers about why they do not seek help for gambling problems.

3.3.4.1 Q Methodology: Data Collection and Analysis

Q-methodology was developed by Stephenson (1953) in order to measure quantitatively the subjectivity of opinion. It provides a foundation for the systematic study of subjectivity. In a Q methodology study, participants are presented with a series of statements on a topic, called the Q-set, undertake a Q sort task and the data gathered is then subjected to a type of analysis which enables the identification of important factors, or groupings, of opinion with the dataset. The process of data collection and analysis is described below.

3.3.4.1.1 Development of the Q-set.

In Q methodology, the *concourse* refers to “*the flow of communicability surrounding any topic*” in “*the ordinary conversation, commentary, and discourse of everyday life*” (Brown, 1993, p.95), and is a collection of all the possible statements a respondent can make about the subject under investigation. A verbal *concourse* may be obtained from literature, observation, and previous research. The researcher must draw a representative sample of statements from the *concourse*, which represents existing opinions and

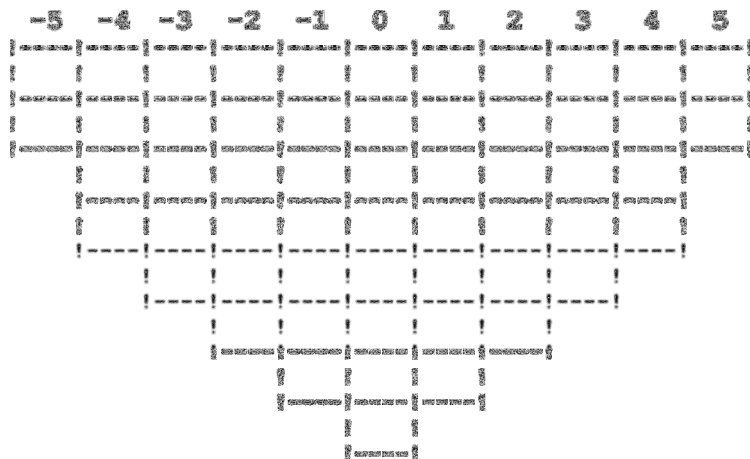
arguments. The development of the Q-set represents a qualitative part of the mixed method approach in Q methodology (Ramlo & Newman, 2011)

3.3.4.1.2 The Q-sort Task

Respondents, called the P-set are asked to rank order the statements from their own point of view. This is known as the Q-sort task, and involves the participants sorting a set of ‘statements’ about the topic/issue under investigation into a hierarchy, within poles which are designated by the researcher e.g. ‘agree/disagree’.

The most common type of sorting grid is the ‘forced’ sort which assumes the statements will be sorted into a normal distribution (see Figure 6).

Figure 6: Example of a Q-sort grid, onto which the Q-set statements are typically sorted



3.3.4.1.3 Analysis and Interpretation

The individual rankings, or viewpoints, are then subject to factor analysis, which can be seen as the quantitative aspect of Q methodology (Ramlo & Newman, 2011). The analysis of data generated from a Q methodology study allows for clusters and/or correlations in responses to be found within the dataset, and is a purely technical, objective procedure (van Exel & de Graf, 2005). The analysis is carried out using a statistical software package, which calculates a correlation matrix of every completed Q-sort. These

correlation matrixes are mathematical representations of level of agreement or disagreement between each individual Q-sort. The correlation matrixes are then subjected to factor analysis, which identifies the natural groupings of Q-sorts according to their similarity, or indeed dissimilarity. The factors which result from the analysis of Q data therefore represent clusters of subjectivity which represent functional distinctions (Brown, 1993; 2002). This yields a model of subjective preferences which can be analysed to identify the 'types' of stories, or attitudes held, by participants. The factor loading will allow for an inference of the particular attitude held by each participant to be made. Each factor resulting from the Q analysis represents a cluster of subjectivity, which can be used to describe a population of viewpoints in a population of people (Risdon et al, 2003).

Q methodology "combines the strengths of both qualitative and quantitative research traditions" (Dennis & Goldberg, 1996, p. 104). Prasad (2001) suggests that Q methodology holds a number of strengths which include that it can be used in a variety of settings, on the same individual, multiple times and with short inter-test intervals. Further advantages of Q methodology are identified by Peritore (1989) who suggests that it respects the integrity of the respondent, results can be recorded anonymously and factorial results cannot be predicted.

It has been suggested that there may be difficulties in ascertaining the reliability of the data obtained using Q methodology, because often different results can be obtained from the same participant. However, the assumption that no individual is ever expected to express the same views on two separate occasions negates this concern (Stainton Rogers, 1991). The methodology also comes under similar criticisms to those faced by survey and interview methodology, that it relies upon the participants responding honestly

(Oppenheim, 1992) which may not occur for a variety of reasons such as the social desirability bias.

Another criticism of Q methodology is that the participants are constrained in the views which they can express as the statements are predetermined by the researcher. However, given appropriate piloting and well informed Q-set design (e.g. statements being drawn from interviews or survey responses) the methodology can be used to extend knowledge and provide answers to such research questions as those asked by this thesis.

An important assumption of Q methodology is that only a finite number of distinct viewpoints exist behind any given topic, and that a well-structured Q-sample containing the widest possible range of viewpoints on the topic will reveal these viewpoints.

3.4 Ethical Issues

3.4.1 Ethical Issues in Qualitative Research

The consideration of ethical issues is an intrinsic part of the research process and attention to ethical implications must be given to the research design from the outset, from formulating the research questions through to conducting interviews, transcribing, analysing and writing up the results. Ethical guidelines for researchers traditionally discuss four main areas: informed consent; confidentiality; consequences; and the role of the researcher. These areas must be continually addressed and reflected upon during the research process (Brinkmann & Kvale 2008).

3.4.3 Ethical Issues in working with Problem Gamblers

Conducting research on sensitive topics can be particularly difficult, and talking to gamblers about their addiction, and the problems and consequences arising from it, may be difficult or upsetting for them. Gamblers often experience feelings of guilt and shame (Lesieur, 1992), and for some being interviewed may mean talking about criminal offences. Developing rapport and trust is an essential element to interviewing participants, and although it should be made clear that interviews were confidential, if unreported crimes were disclosed then participants were informed that reporting these was at the authority of the researcher. Although crime was discussed in areas of this research, the criminal act was already under investigation and as such did not need to be reported.

Given that the area of focus for this research was barriers to treatment access, it was important that individuals were given appropriate contact details for additional help if it was needed or wanted, as suggested by Alty and Rodham (1998). During the period of research, links were established with GamCare, the national charity for treatment, advice and information for anyone affected by a gambling problem. A mechanism was established for direct referrals to the service to be made, ensuring that if issues arose during interviews requiring immediate support, a swift treatment plan could be put in place.

3.4.2 Ethical Issues in working with Adolescents

Obtaining informed consent from participants is a vital process in any research, however extra consideration must be given in cases where those taking part in the research are considered to be minors (aged under eighteen in the UK). Usually consent from an adult is required for participation in research for minors, however when discussing sensitive topics, such as problem gambling, participants may be reluctant to seek consent from a parent or guardian. The age of consent may be considered to be sixteen in such cases, but

responsible procedures must be followed to ensure the protection of vulnerable participants (Munford & Sanders, 2004).

Chapter Four: Treatment Provision for Problem Gambling within the National Health Service: A Brief Review

4.1 Introduction

As part of the wider research programme into the barriers to treatment access for problem gambling amongst young people in the UK it is imperative to have an understanding of the provision of such treatment, and to assess the extent to which such services are used. The types of intervention for problem gambling include counselling, psychotherapy, cognitive-behavioural therapy, advisory services (including internet-based advice), residential care, pharmacotherapy, and multimodal treatment (combinations of treatment options) (Griffiths, 1996; Griffiths, 2005; Griffiths, Bellringer, Farrell-Roberts & Freestone, 2001; Griffiths & Delfabbro, 2001; Griffiths & MacDonald, 1999; Hayer et al, 2005).

Within the UK, many private and charitable organisations provide help for those with gambling problems (Griffiths, 2007). Although we know that the rate of help-seeking for problem gambling remains low, young people who are likely to seek formal, professional help for a gambling problem would hypothetically do so through their local GP surgery, who would, if following the appropriate care pathway, then refer on to specialist services. Treatment can also be accessed via self-referrals to services, can be accessed privately and may sometimes be mandated as part of a court order.

The NHS has a complex funding and managerial structure, which is often reviewed and to which alterations may be made. At the time this research was conducted (June to July 2009) the body was organised into NHS Trusts, of which there were 175 Acute NHS Trusts (managing hospitals and providing some community care), 152 Primary Care Trusts (managing GPs, dentists, opticians, pharmacists and NHS walk-in centres and NHS

Direct), 115 NHS Foundation Trusts (providing hospitals run under a model of management by local managers, staff and the general public), 60 Mental Health NHS Trusts (providing health and social care for those with mental health problems), and 12 Ambulance Trusts (providing emergency access to healthcare). The specific care and services provided by each type of Trust was subject to some degree of overlap. For example, a mental health service may have been located within an Acute Trust's hospital but funded by a Mental Health Trust, and some services may have received double funding streams. The move toward multidisciplinary care is making the structure increasingly intricate. The complex nature of the NHS makes it difficult for comprehensive audit and evaluation of service provision on a nationwide level to be carried out.

In his 2007 review 'Gambling addiction and its treatment within the NHS' Griffiths found that there were 'almost no' treatment services available for problem gamblers on the NHS (p. 16). Almost all treatment was at that point funded by private and charitable organisations, the larger of which received indirect funding from the gambling industry. Griffiths made recommendations that more funding be provided by the gambling industry to fund research, prevention, intervention and treatment programmes, and that treatment should be provided within the NHS, either as a standalone service or as part of a wider, established drug and alcohol addiction service. Griffiths called for education and training for GPs to assist in the diagnosis and appropriate referral of those exhibiting gambling problems, and highlighted the need for accessible treatment and information provision to be provided nationwide, as opposed to the uneven and sparse distribution of provision that was currently available. Griffiths also emphasised the need for routine screening for gambling problems within addictions services, mental health centres, outpatient clinic and prison and probations services.

4.1.1 Aim

Conducted more than two years after the publication of the British Medical Association review (Griffiths, 2007), this study aimed to assess what services were currently being provided within the NHS for those with gambling problems in order to provide context for the research programme investigating barriers to treatment access for young people with gambling problems in the UK.

4.2 Methodology

In August 2009, a total of 327 letters were sent to all Primary Care Trusts, Foundation Trusts and Mental Health Trusts in the UK requesting information about problem gambling service provision and past year treatment of gambling problems within their Trust. These requests were made under the Freedom of Information Act (2001) legislation, which requires all public authorities to make available any (non-personally identifiable) data they hold to the public (although certain caveats apply). Acute Trusts and Ambulance Trusts were not included in the process as after initial enquiries it became clear that mental health problems are not catered for by these agencies. The data request was comprehensive and covered aspects of treatment provision as follows:

- Types of services offering problem gambling treatment;
- Number and job title of qualified mental health professionals within each service who offer treatment for gambling problems;
- Number of problem gambling specialists within the Trust;
- Lower age limit for referral to service;

Also covered in the request for information was specific referral data for any individuals that had been referred for treatment of a gambling problem within each trust as follows:

- Number of referrals where problem gambling was the primary reason for referral;
- Age of referrals;
- Gender of referrals;
- Type of treatment offered;
- How many attended first appointment;
- How many never attended;
- How many completed treatment;
- How many dropped out of treatment part way through;
- How many were still in treatment (at the end of July 2009).

The request letter also contained information about the research team and the reason for the collection of the data. Under the regulations of the Freedom of Information Act, all requests should be acknowledged within 48 hours and responses should be provided within 20 working days. All but two of the letters met the appropriate time schedule, and where the acknowledgement and response were delayed adequate communication was maintained about the problem.

4.3 Results

The vast majority of responses to the information requests (318 of the 327 responses) were that the Trust in question did not provide a specialist service for treating those with gambling problems and/or that no referrals had been made to the Trust for anyone with a gambling problem in the previous 12 months. Where the only response given was that no one had been referred with a gambling problem, clarification was sought as to whether there was a service commissioned within the Trust despite a lack of referrals and in all cases it was confirmed that no service was available for referrals.

“The Trust holds no information in respect of the request, and is not commissioned to provide any gambling services.”

(Response ID 31, Mental Health Trust, North West England)

Some responses indicated that gambling problems would not be referred as they were not classed as a mental health problem:

“Unfortunately we do not have the information you require as the primary reasons for referrals for our patients are mental health issues.”

(Response ID 200, Mental Health Trust, East of England)

“The Trust does not have a specific service for gamblers but if they had a mental health/or an addiction such as drug and alcohol issues they could be referred to the other services.”

(Response ID 95, Primary Care Trust, West Midlands)

In some cases the possibility of co-morbid treatment was identified, but that problem gambling would not be recorded as the primary reason for referral to the service:

“It may be that occasionally gambling addiction is a secondary issue but our record will be coded for the primary issue.”

(Response ID 200, Mental Health Trust, East of England)

“Where gambling co-exists with alcohol misuse, it is generally possible to offer help alongside that for the alcohol and, in this regard, we are unable to provide any data on referrals for gambling services.”

(Response ID 154, Mental Health Trust, South East England)

“However, people may receive some additional support, advice and treatment where their addiction is co-morbid with other addictions (such as to drugs or alcohol). These interventions do not relate specifically to gambling addictions but may be of benefit to individuals.”

(Response ID 316, NHS Foundation Trust, South East England)

Seven Trusts confirmed that they did not provide specialist problem gambling services, but did provide information about third party services to which people with gambling problems could be directed. These included GamCare, Gordon House (now the Gordon Moody Association), and Gamblers Anonymous, in addition to local community resources.

“The Trust has no services or specialists dealing with gambling addictions. Patients requiring this type of service are referred to third party organisations that are more specialised in this area.”

(Response ID 77, NHS Foundation Trust, North of England)

“The Trust does not receive specific funding to provide services to people who may be addicted to gambling. Our teams will have a general awareness of such issues and may signpost people to services such as Gamblers Anonymous.”

(Response ID 316, NHS Foundation Trust, South East England)

One NHS Trust identified a referral of one patient with a gambling addiction, who was at the time of response being treated with solution focused/narrative therapy by a clinician with no specialist training in treating gambling problems. However, this Trust is a specialist Learning Disability Trust so it is likely, but unclear, that this patient was also

being treated for co-morbid mental health difficulties. One NHS Trust identified a specialist service for those with problem gambling.

4.4 Discussion

The data obtained in this study highlights a number of issues of concern. Although one specialist service has been set up since the publication of the BMA report in 2007, the overwhelming majority of the population of the UK is still unable to receive localised care for gambling problems on the NHS. Although the specialist service accepts referrals from anyone in the UK and endeavours to work with local support agencies for those affected by problem gambling, this does not fulfil the recommendations made by Griffiths (2007) which suggest that in order to tackle problem gambling, treatment services need to be available and accessible in the local area.

Although some treatments and interventions may be available to problem gamblers through the NHS locally if the problem gambler has a co-morbid addiction or other mental health problem that acts as the primary reason for referral, under this referral model the gambling problem is marginalised as a secondary issue from the beginning of the referral pathway. This is an important finding as it has implications for both funding of services and for general awareness and acceptance of problem gambling as a valid mental health issue. This is also linked to the fact that some responses suggested that problem gambling would not even be classed as a mental health issue, which highlights a clear need for raising awareness and educating health professionals around this issue.

Only seven of 327 NHS Trusts could provide information about where people with gambling problems could be referred. This data was not specifically requested in the initial information request, which may account for the small number of Trusts that provided this

information. Nevertheless, this serves as an indicator of the lack of knowledge and information about where problem gamblers can get assistance.

There were significant advantages to using the Freedom of Information Act (2001) legislation as a tool to support survey data collection in this study. The response rate was likely to be very high and responses were likely to be received promptly, as the legislation requires organisations to respond to all requests within twenty working days. The response rate was indeed 100%, and where there was a delay in responding (in two cases) this was minimal and adequate communication was maintained with the organisation about the delay. Conducting research using this method is expedient, as the contact details for FOI officers are usually prominently displayed on the websites or other literature of large organisations such as NHS Trusts, thus reducing the amount of time taken to prepare and disseminate surveys. This was likely be much more time consuming if trying to find the correct contact person(s) within the correct department(s) within each organisation. There are potential disadvantages with the method however: although the FOI officer is required to take reasonable steps to gather the information required, they may not be able to provide nuanced detail that could be potentially provided by those working directly within the departments providing services that were being examined in this study. Care should be taken by researchers to balance the scope of a Freedom of Information Act request with the potential for contribution to knowledge in the field, so as not to create an administrative burden for organisations which may already be stretched.

The implications of this study could be far reaching. It is imperative that further exploration of the co-morbidity of gambling and other mental health problems and addictions is undertaken. NHS services need to be encouraged to see gambling problems as a primary reason for referral and a valid treatment option. Although NHS provision of

problem gambling treatment services is improving, there is still a long way to go to provide localised, problem specific treatment to problem gamblers in the UK.

Chapter Five: Adolescent Attitudes to Problem Gambling: Indicators and Consequences.

5.1 Introduction

Despite legislative efforts to prevent the participation in many forms of regulated gambling by children and adolescents, it is clear that youth continue to engage in both regulated forms of gambling (e.g. lotteries, scratchcards, online gambling, bookmakers) and non-regulated forms of gambling (e.g. card games, betting amongst peers) (Derevensky & Gupta, 2004a). It has been estimated that between 60% and 80% of adolescents report having taken part in gambling activities within the past year (Abbott et al. 2004; Derevensky & Gupta, 2004b; National Research Council, 1999). This is comparable with the 73% of adults who are reported to have taken part in gambling activities in the past year in Great Britain (Wardle et al, 2011). The majority of adolescents who participate in gambling activities do so with no significant harm to themselves or others. However, the most recent research looking at the prevalence of youth gambling and problem gambling in Britain identified that 21% of 12-15 year olds have gambled within the last week, and that 2% of adolescents are estimated to have a gambling problem (IPSOS MORI 2009). Whilst this figure shows a decrease in both rates of participation and rates of problem gambling since previous prevalence studies carried out in 2003 and 2005 (MORI IGRU, 2006), the figures are still worryingly high. The rate of problem gambling found in adolescents is over twice as high as the problem gambling rate found in adults (0.9%: Wardle et al, 2011), and suggests that young people may be particularly susceptible to developing gambling problems.

It has been estimated in other jurisdictions that between 3% to 8% of adolescents have a gambling problem, with a further 10% to 15% being 'at risk' for developing a gambling

problem (Derevensky & Gupta, 2007). Male adolescents tend to exhibit problem gambling more so than female adolescents (Abbott et al, 2004; Derevensky & Gupta, 2004a, National Research Council, 1999).

While the body of research investigating correlates of youth gambling problems is comparatively large, there are areas that are under-researched and as a result are not fully explored. Very little is known about gambling and problem gambling as it is understood by young people.

5.1.1 Aim

The aim of this study was to recode and explore an existing dataset to develop an understanding of the types of issues that young people feel are pertinent to problem gambling in terms of knowledge, indicators and consequences, and most importantly how they might recognise signs of gambling problems in their peers and encourage them to seek treatment should they need it. This will inform the first objective of the thesis which is to explore the attitudes and perceptions that young people hold towards problem gambling.

5.2 Method

As part of a previous research exercise, a simple ten-item, open-ended questionnaire was developed by the International Gaming Research Unit at Nottingham Trent University in conjunction with TACADE, a leading educational charity. The questionnaire explored gambling, problem gambling, and what both of these meant to adolescents. Educational settings across the UK were sampled to administer the questionnaire, which was often carried out in lessons which formed part of the PSE (Personal, Social and Emotional) education curriculum. The questionnaire was administered to 2587 young people aged between 10 and 22. The vast majority of those sampled were under the age of 18 years. As

described in Chapter 3, this was thought to be the most effective method of data collection, as it meant that there was a high rate of return as administration and collection were carried out by teachers who ensured questionnaires were correctly completed and returned.

Permission was sought to carry out a secondary analysis of this data, as its original purpose was to inform the development of educational resources, and as such it had been subjected to a simple qualitative content analysis but had never been subjected to rigorous statistical analysis to explore similarities and differences in the data.

The questionnaire consisted of ten items, as described in Figure 7. Each item asked for an open ended response. The responses were then subjected to coding using content analysis and results were then entered into SPSS.

The data were then subjected to a series of statistical analyses to describe and explore the dataset. Data was subjected to t-tests to identify age effects, and chi square to identify gender effects.

Figure 7: Content of Open-ended Questionnaire

1. Write down a few words that come into your head when you think about the word 'gambling'.
2. What types of gambling have you heard about?
3. At what age do you think you are allowed to gamble?
4. Why do you think some people choose to gamble?
5. Why do you think some people choose not to gamble?
6. What do you think about people who gamble?
7. What might be some of the problems that could happen because of gambling?
8. How would you know if a friend had a problem with their gambling?
9. What could you do to help a friend who had a problem with their gambling?
10. Anything else you wish to say about gambling?

5.3 Results

5.3.1 Descriptive Data

Of the 2587 participants who returned questionnaires, 55% were male and 45% were female. All participants were aged between 10 and 22, with the mean age being 13.6 years. The vast majority of respondents were aged between 12 and 18. Table 2 shows the numbers of participants in terms of age.

Table 2: Participants by age

Age	Participants (n)	Participants (%)
10	4	0.15%
11	80	3.09%
12	381	14.73%
13	618	23.89%
14	1068	41.28%
15	274	10.59%
16	122	4.72%
17	24	0.93%
18	12	0.46%
19	0	0.00%
20	3	0.12%
21	0	0.00%
22	1	0.04%
Total	2587	100%

As responses to each question were open ended, responses were coded and then for the purposes of statistical analysis were entered into SPSS as categorical variables, whereby each participant either did or did not answer the question with that response variable.

The responses were then subjected to descriptive analysis and both Chi Square and Independent Samples T-test analyses in order to determine whether the data showed any gender or age effects. Summary data for responses to questions one through ten is presented in Tables 3 to 12. It should be noted that not all respondents answered all questions, and often respondents provided more than one answer. Therefore response rate varies between questions. Examples of responses for each category are reported per question in Appendix 1.

The table column entitled 'Overall Responses' shows the percentage of respondents who answered the question with a particular response; similarly 'Male' and 'Female' columns show the percentage from each gender who gave that response. The values of the Chi Square analysis for each response are included to show whether any difference in gender was significant. The column entitled 'Mean Age – Positive' gives the mean age of all the

respondents who gave that response to the questions, and 'Mean Age – Negative' shows the inverse: the mean age of those who did not give that response. The values of the Independent Samples T-test are given to show whether any differences in mean age were significant.

Table 3: Responses to Question 1: Write down a few words that come into your head when you think about the word 'gambling'

The most frequently used words about gambling	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: negative (SD)	<i>t</i> (df) <i>p</i>
Winning prizes/money	87.3	47.3	40.0	2.273 (1) 0.132	13.58 (1.165)	13.69 (1.128)	1.623 (2508) 0.105
Type of gambling	83.5	44.4	39.1	1.161 (1) 0.281	13.59 (1.161)	13.59 (1.160)	0.013 (2508) 0.989
Negative consequences	41.2	22.4	18.7	0.542 (1) 0.462	13.72 (1.110)	13.50 (1.187)	4.782 (2508) 0.000*
Gambling Venue	31.9	16.0	15.9	5.768 (1) 0.016*	13.65 (1.132)	13.56 (1.173)	1.858 (2508) 0.063
Gambling Location	15.3	8.6	6.8	0.900 (1) 0.343	13.59 (1.095)	13.59 (1.173)	0.95 (2508) 0.924
Gambling word (e.g. bet)	13.7	7.3	6.5	0.054 (1) 0.815	13.65 (1.129)	13.58 (1.166)	0.977 (2508) 0.328
Gambling item (e.g. chip)	13.1	8.5	4.5	20.480 (1) 0.000*	13.66 (1.278)	13.58 (1.142)	1.102 (2508) 0.271
People	8.8	5.5	3.2	8.855 (1) 0.003*	13.30 (1.358)	13.62 (1.137)	3.947 (2508) 0.000*
Emotion	8.1	3.5	4.6	8.925 (1) 0.003*	13.93 (1.012)	13.56 (1.169)	4.339 (2508) 0.000*
Other	2.2	1.7	0.5	12.945(1)0.000*	13.48 (0.966)	13.59 (1.165)	0.692 (2508) (0.489)

* Significant at $p < 0.05$

Table 4: Responses to Question 2: What types of gambling have you heard about?

Types of Gambling	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
Poker	48.3	25.5	22.8	0.011 (1) 0.915	13.65 (1.110)	13.61 (1.143)	0.787 (2379) 0.431
Non-poker card games	44.1	22.1	22.0	4.477 (1) 0.034*	13.63 (1.088)	13.63 (1.157)	0.168 (2379) 0.867
Horse Racing	42.6	22.5	20.1	1.155 (2) 0.561	13.70 (1.099)	13.58 (1.145)	2.614 (2378) 0.009*
Slot Machines	40.8	21.9	18.9	0.757 (1) 0.384	13.73 (1.106)	13.56 (1.137)	3.485 (2379) 0.001*
Casinos	21.2	11.3	10.0	0.061 (1) 0.805	13.62 (1.107)	13.63 (1.133)	0.214 (2379) .831
Lotteries	21.1	11.1	10	0.011 (1) 0.917	13.64 (1.123)	13.63 (1.129)	0.277 (2379) 0.781
Roulette	18.0	9.7	8.3	0.404 (1) 0.525	13.74 (1.129)	13.61 (1.126)	2.174 (2379) 0.030*
Sports Betting	16.2	8.2	8	0.788 (1) 0.375	13.71 (1.031)	13.61 (1.144)	1.579 (2379) 0.115
Dog Racing	11.6	7.7	3.9	24.092 (1) 0.000*	13.66 (1.245)	13.63 (1.111)	0.545 (2379) 0.586
Arcade Gambling	7.2	4.8	2.4	14.656 (1) 0.000*	13.46 (1.036)	13.64 (1.133)	2.090 (2379) 0.037*
Bingo	4.8	2.4	2.4	0.441 (1) 0.506	13.74 (1.053)	13.62 (1.131)	1.069 (2379) 0.285
Internet Gambling	4.6	2.8	1.8	2.558 (1) 0.110	13.19 (1.027)	13.65 (1.127)	4.202 (2378) 0.000*
Bookmakers	3.5	2.6	1.0	14.047 (1) 0.000*	13.95 (1.191)	13.62 (1.123)	2.671 (2378) 0.008*
Scratchcards	3.4	1.7	1.7	0.224 (1) 0.636	13.67 (1.414)	13.63 (1.116)	0.296 (2378) 0.767

* Significant at $p < 0.05$

Table 5: Responses to question 3: At what age do you think you are allowed to gamble?

Perceived age at which allowed to gamble	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
18	62	31.5	30.5	1.586 (1) 0.208	13.69 (1.121)	13.59 (1.102)	2.079 (2304) 0.038*
16 lottery, 18 generally	18.5	9.3	9.2	0.556 (1) 0.456	13.67 (1.063)	13.65 (1.126)	0.371 (2304) 0.711
21	8.3	4.5	3.8	0.355 (1) 0.551	13.75 (1.218)	13.65 (1.105)	1.216 (2304) 0.224
Any age	5.4	3.3	2.2	3.504 (1) 0.061	13.30 (1.026)	13.67 (1.116)	3.628 (2304) 0.000*
16	14.8	7.0	7.8	3.252 (1) 0.071	13.85 (0.948)	13.62 (1.138)	3.587 (2304) 0.000*
Other	2.6	1.6	1.0	2.371 (1) 0.124	13.53 (1.096)	13.66 (1.115)	0.855 (2304) 0.392

* Significant at $p < 0.05$

Table 6: Responses to question 4: Why do you think some people choose to gamble?

Why do people gamble	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
Win money	68.1	31.5	36.7	0.123 (1) 0.726	13.61 (1.128)	13.57 (1.187)	0.673 (2464) 0.501
Fun/enjoyment	21.2	9.4	11.8	0.944 (1) 0.331	13.55 (1.163)	13.61 (1.143)	1.005 (2464) 0.315
Excitement	12.9	4.4	8.5	22.150 (1) 0.00*	13.62 (1.260)	13.59 (1.130)	0.403 (2464) 0.687
Poor/not rich	11.2	7.3	3.9	17.393 (1) 0.00*	13.65 (1.238)	13.59 (1.135)	0.821 (2464) 0.412
Bored	8.6	2.5	6.1	28.129 (1) 0.00*	13.23 (1.314)	13.63 (1.124)	4.837 (2464) 0.000*

* Significant at $p < 0.05$

Table 7: Responses to question 5: Why do you think some people choose not to gamble?

Why do people choose not to gamble?	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
Avoid debt	54.9	26.1	28.8	0.650 (1) 0.420	13.63 (1.139)	13.55 (1.178)	1.789 (2470) 0.072
Fear of addiction	23.3	12.2	11.1	0.280 (1) 0.597	13.54 (1.141)	13.61 (1.162)	1.424 (2467) 0.154
Too risky	13.8	8.8	5.0	18.169 (1) 0.000*	13.65 (1.260)	13.59 (1.140)	0.840 (2470) 0.401
Sin	9.4	4.4	5.0	4.022 (1) 0.045*	13.75 (1.001)	13.58 (1.171)	2.127 (2470) 0.034*
Not likely to win	8.0	5.2	2.8	11.848 (1) 0.001*	13.36 (1.316)	13.62 (1.140)	2.987 (2470) 0.003*
No fun/boring	4.2	3.0	1.3	11.685 (1) 0.001*	13.65 (1.143)	13.59 (1.158)	0.465 (2470) 0.642

* Significant at $p < 0.05$

Table 8: Responses to question 6: What do you think about people who gamble?

What do you think about people who gamble?	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
Negative	46.5	22.3	24.2	12.961 (1) 0.000*	13.66 (1.165)	13.63 (1.083)	0.763 (2315) 0.446
Up to the individual	16.1	7.7	8.4	3.141 (1) 0.076	13.82 (0.962)	13.61 (1.147)	3.358 (2315) 0.001*
Bad people	9.6	5.4	4.2	2.075 (1) 0.150	13.65 (1.285)	13.64 (1.103)	0.139 (2315) 0.890
Exciting	35.2	17.4	17.8	3.409 (1) 0.065	13.82 (1.062)	13.55 (1.141)	5.677 (2314) 0.000*
OK in moderation	8.5	4.5	4.1	0.032 (1) 0.859	13.78 (1.310)	13.63 (1.102)	1.745 (2315) 0.081
Normal	2.5	1.6	0.9	2.454 (1) 0.117	13.60 (1.042)	13.65 (1.124)	0.284 (2315) 0.776
Feel sorry for them	7.2	4.4	2.8	6.891 (1) 0.009*	13.37 (1.008)	13.67 (1.126)	3.367 (2314) 0.001*
They are rich	2.3	1.6	0.7	5.565 (1) 0.018*	14.36 (1.058)	13.63 (1.118)	4.707 (2315) 0.000*

* Significant at $p < 0.05$

Table 9: Responses to question 7: What might be some of the problems that could happen because of gambling?

What problems could happen because of gambling?	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
Lose money	58.4	31.0	27.4	0.716 (1) 0.397	13.52 (1.175)	13.67 (1.126)	-3.156 (2490) 0.002*
Addiction	19.7	10.6	9.1	0.011 (1) 0.918	13.80 (0.946)	13.53 (1.197)	4.610 (2490) 0.000*
Debt	35.1	18.3	16.8	1.383 (1) 0.240	13.80 (1.114)	13.46 (1.162)	7.056 (2490) 0.000*
Behavioural/emotional/alcohol problems	8.1	3.6	4.5	8.342 (1) 0.004*	13.92 (1.014)	13.55 (1.164)	4.391 (2490) 0.000*
Crime	13.0	8.5	4.5	21.008 (1) 0.000*	13.63 (1.270)	13.57 (1.139)	0.868 (2490) 0.385
Death	4.9	3.6	1.4	17.980 (1) 0.000*	13.76 (1.081)	13.57 (1.160)	1.738 (2490) 0.082
Relationship problems	10.3	4.8	5.5	5.460 (1) 0.019*	13.74 (1.020)	13.56 (1.170)	2.321 (2490) 0.20

* Significant at $p < 0.05$

Table 10: Responses to question 8: How would you know if a friend had a problem with gambling?

How would you know if a friend had a problem with gambling?	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
Gambling all the time	34.3	16.3	18.0	8.521 (1) 0.004*	13.71 (1.093)	13.63 (1.125)	1.774 (2304) 0.76
Rich	3.6	2.6	1.0	13.365 (1) 0.000*	13.36 (1.453)	13.67 (1.099)	-2.497 (2304) 0.013*
Spending everything at once	1.3	1.0	0.3	9.683 (1) 0.002*	13.80 (0.407)	13.65 (1.121)	0.718 (2304) 0.473
No money/possessions	46.4	22.2	24.2	12.578 (1) 0.000*	13.68 (1.155)	13.63 (1.078)	0.974 (2304) 0.330
Borrowing	15.7	7.5	8.3	3.466 (1) 0.063	13.88 (0.911)	13.61 (1.144)	4.186 (2304) 0.000*
Behavioural/emotional changes	9.6	5.4	4.2	2.159 (1) 0.142	13.67 (1.281)	13.65 (1.096)	0.209 (2304) 0.835
Talking about gambling	2.5	1.6	1.0	2.482 (1) 0.115	13.60 (1.042)	13.66 (1.117)	-0.355 (2304) 0.722
I wouldn't know	7.3	4.5	2.8	7.316 (1) 0.007*	13.36 (1.011)	13.68 (1.119)	-3.605 (2304) 0.000*
Crime	2.3	1.6	0.7	5.604 (1) 0.018*	14.36 (1.058)	13.64 (1.111)	4.671 (2304) 0.000*
They would tell me	8.5	4.4	4.0	0.017 (1) 0.897	13.81 (1.301)	13.64 (1.095)	1.970 (2304) 0.49

* Significant at $p < 0.05$

Table 11: Responses to question 9: What could you do to help a friend who had a problem with their gambling?

How could you help a friend with a gambling problem?	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	<i>t</i> (df) <i>p</i>
Keep away from gambling premises/activities	21.0	12.0	9.1	5.514 (1) 0.019*	13.45 (1.017)	13.74 (1.112)	5.108 (2240) 0.000*
Keep their money	9.7	5.4	4.3	1.292 (1) 0.256	13.60 (0.948)	13.68 (1.113)	0.998 (2240) 0.319
Tell someone	1.1	0.5	0.5	0.043 (1) 0.836	13.25 (0.442)	13.68 (1.103)	1.904 (2240) 0.057
Talk to them	31.3	13.6	17.7	31.144 (1) 0.000*	13.79 (1.268)	13.62 (1.007)	3.534 (2240) 0.000*
Distract them	15.3	7.1	8.2	5.078 (1) 0.024*	13.74 (0.888)	13.66 (1.132)	1.174 (2240) 0.241
Lend money	11.6	7.1	4.5	10.507 (1) 0.001*	13.59 (1.062)	13.69 (1.103)	1.292 (2240) 0.196
Take to treatment	19.1	8.3	10.7	14.973 (1) 0.000*	13.91 (1.248)	13.62 (1.053)	4.985 (2240) 0.000*
Hit them	1.3	1.0	0.3	8.719 (1) 0.003*	13.62 (0.820)	13.68 (1.102)	0.265 (2240) 0.791
Do not know	3.7	2.4	1.3	4.776 (1) 0.029*	14.01 (0.757)	13.66 (1.108)	2.858 (2240) 0.004*
Can't do anything	2.3	1.8	0.5	14.564 (1) 0.000*	13.92 (1.218)	13.67 (1.087)	1.647 (2276) 0.100

* Significant at $p < 0.05$

Table 12: Responses to question 10: Anything else you wish to say about gambling?

How could you help a friend with a gambling problem?	Overall responses (%)	Male (%)	Female (%)	χ^2 (df) <i>p</i>	Mean Age: Positive (SD)	Mean Age: Negative (SD)	t (df) <i>p</i>
I will not gamble	2.6	1.3	0.6	8.429 (1) 0.003*	13.62 (0.820)	13.68 (1.102)	0.265 (2240) 0.791
Nothing	2.3	1.8	0.5	14.584 (1) 0.000*	13.92 (1.218)	13.67 (1.089)	1.648 (2270) 0.100
Gambling is good/cool	2.7	1.4	0.3	4.673 (1) 0.037*	14.01 (0.757)	13.66 (1.108)	2.858 (2240) 0.004*

* Significant at $p < 0.05$

5.3.2 Gender Differences

5.3.2.1 Word associations with the word ‘Gambling’

The most common responses to the question “Write down a few words that come onto your head when you think about gambling” were words associated with winning, prizes and money (87.3%), types of gambling (83.5%) and negative consequences (41.2%). None of these exhibited significant gender effects. However, males were significantly more likely than females to respond with words associated with gambling venues ($\chi^2_{(df=1)}=5.768, p<0.05$), gambling items (e.g poker chips) ($\chi^2_{(df=1)}=20.480, p<0.05$), certain people ($\chi^2_{(df=1)}=8.855, p<0.05$), or something ‘other’ ($\chi^2_{(df=1)}=12.945, p<0.05$). Females were significantly more likely than males to respond with words describing emotions ($\chi^2_{(df=1)}=8.925, p<0.05$).

5.3.2.2 Awareness of types of gambling

The most common responses to the question “What types of gambling have you heard about?” were Poker (48.3%), Non-poker card games (44.1%) and Horse Racing (42.6%). Gender effects were found with males being significantly more likely to have heard about Non-poker card games ($\chi^2_{(df=1)}=1.155, p<0.05$), Dog racing ($\chi^2_{(df=1)}=24.092, p<0.05$), Arcade gambling ($\chi^2_{(df=1)}=14.656, p<0.05$) and bookmakers ($\chi^2_{(df=1)}=14.047, p<0.05$). There were no significant gender effects showing more females having heard about types of gambling than males.

5.3.2.3 Legal gambling age

The most common responses to the question “At what age do you think you are allowed to gamble?” were 18 (62%), ‘18 generally but 16 for the lottery’ (18.5%) and 16 (14.8%). Other responses were 21 (8.3%) and ‘at any age’ (5.4%). No significant gender effects were found for responses to this question.

5.3.2.4 Reasons for participation in gambling

The most common responses to the question “Why do you think people choose to gamble?” were ‘To win money’ (68.1%), ‘For fun/enjoyment’ (21.2%) and ‘Excitement’ (12.9%). Females were significantly more likely than males to suggest that people gamble for excitement ($\chi^2_{(df=1)}=22.150, p<0.05$) and because they are ‘Bored’ ($\chi^2_{(df=1)}=28.129, p<0.05$). Males were significantly more likely to suggest people gambled because they were poor or not rich ($\chi^2_{(df=1)}=17.393, p<0.05$).

5.3.2.5 Reasons for non-participation in gambling

The most common responses to the question “Why do you think some people choose not to gamble were ‘To avoid debt’ (54.9%), ‘Fear of addiction’ (23.3%) and because it is ‘Too risky’ (13.8%). Males were significantly more likely than females to suggest that people choose not to gamble because it is ‘Too risky’ ($\chi^2_{(df=1)}=18.169, p<0.05$), because they ‘aren’t likely to win’ ($\chi^2_{(df=1)}=11.848, p<0.05$) or because it is ‘boring’ ($\chi^2_{(df=1)}=11.685, p<0.05$). Females were significantly more likely than males to suggest that people choose not to gamble because it is a ‘sin’ ($\chi^2_{(df=1)}=4.022, p<0.05$).

5.3.2.6 Perceptions about those who gamble

The most common responses to the question “What do you think about people who gamble?” were to say something negative about them as individuals (e.g. “*loser*”, “*tramp*”) (46.5%), that they are ‘Exciting’ (35.2%), or that it is an individual choice (16.1%). Significant gender effects were found, with females being significantly more likely than males to say something negative ($\chi^2_{(df=1)}=12.961, p<0.05$). Males were significantly more likely than females to say that they felt sorry for those who gamble ($\chi^2_{(df=1)}=6.891, p<0.05$) or that they must be rich ($\chi^2_{(df=1)}=5.565, p<0.05$).

5.3.2.7 Consequences of gambling

The most common responses to the question “What might be some of the problems that could happen because of gambling?” were losing money (58.4%), debt (35.1%) and addiction (19.7%). Significant gender effects were found, with females being more likely than males to suggest behavioural, emotional or alcohol problems ($\chi^2_{(df=1)}=8.342$, $p<0.05$) or relationship problems ($\chi^2_{(df=1)}=5.460$, $p<0.05$). Males were more likely than females to suggest crime ($\chi^2_{(df=1)}=21.008$, $p<0.05$) or death ($\chi^2_{(df=1)}=17.980$, $p<0.05$) as consequences of gambling.

5.3.2.8 Indicators of problem gambling in a friend

The most common responses to the question “How would you know if a friend had a problem with their gambling?” were having no money or possessions (46.4%), gambling all the time (34.3%) and borrowing from them (15.7%). Females were significantly more likely than males to identify the following as indicators of a gambling problem: gambling all the time ($\chi^2_{(df=1)}=8.521$, $p<0.05$) and having no money and few possessions ($\chi^2_{(df=1)}=12.578$, $p<0.05$). Males were more likely than females to identify the following as indicators of a gambling problem: being rich ($\chi^2_{(df=1)}=13.365$, $p<0.05$); spending all their money at once ($\chi^2_{(df=1)}=9.638$, $p<0.05$); and being involved in crime ($\chi^2_{(df=1)}=5.604$, $p<0.02$). Males were also more likely to say they would not be able to identify if a friend had a gambling problem ($\chi^2_{(df=1)}=7.316$, $p<0.05$).

5.3.2.9 Helping Behaviour

The most common responses to the question “What could you do to help a friend who had a problem with their gambling were talking to them (31.3%), keeping them away from gambling premises or activities (21%), and taking them to treatment (19.1%). Significant gender effects were found, with males being significantly more likely than

females to say they would keep their friends away from gambling activities and venues ($\chi^2_{(df=1)}=5.514, p<0.02$) admit that they wouldn't know how to help ($\chi^2_{(df=1)}=4.776, p<0.03$) to suggest that there was nothing they could do to help ($\chi^2_{(df=1)}=14.428, p=0.00$), or suggest maladaptive helping behaviour such as violence ($\chi^2_{(df=1)}=8.719, p=0.003$) or lending their friend more money ($\chi^2_{(df=1)}=10.507, p<0.001$). Females were more likely than males to say they would talk to their friend about the problem ($\chi^2_{(df=1)}=31.144, p=0.00$), try to distract them/occupy them ($\chi^2_{(df=1)}=5.087, p<0.02$), or direct them towards some form of treatment for problem gambling ($\chi^2_{(df=1)}=14.973, p=0.00$). Other types of helping behaviour that were suggested but did not have significant gender differences were imposing financial control and telling an authority figure (e.g. parent, teacher).

5.3.2.10 Any other thoughts on gambling

When asked the question “Anything else to say about gambling?” very few participants gave a response. Those that did respond suggested one of three things: Gambling is good/cool (2.7%); I would not gamble (2.6%); or gave the response ‘nothing’ (2.7%).

While significant gender effects were found showing that males were more likely to make any of the responses than females, given the small response size and lack of utility of such data the statistical significances are not described, as these can be found in Table 12.

5.3.3 Age Differences

5.3.3.1 Word associations with the word ‘gambling’

There were significant age effects found in the data. Those who responded to the question “write down a few words that come into your head when you think about gambling” with negative consequences ($t_{(df=2508)}=4.782, p<0.05$) or types of emotion

($t_{(df=2508)}=4.339, p<0.05$) were more likely to be older, and those who named particular people were more likely to be younger ($t_{(df=2508)}=3.947, p<0.05$).

5.3.3.2 Awareness of types of gambling

The following responses to the question “What types of gambling have you heard about?” were significantly more likely to be given if the participant was older: horse racing ($t_{(df=2378)}=2.614, p<0.05$); slot machines ($t_{(df=2379)}=3.485, p<0.05$); roulette ($t_{(df=2379)}=2.174, p<0.05$); and bookmakers ($t_{(df=2378)}=2.671, p<0.05$). Younger respondents were more likely to suggest they had heard about arcade gambling ($t_{(df=2379)}=2.090, p<0.05$) and internet gambling ($t_{(df=2378)}=4.202, p<0.05$).

5.3.3.3 Legal gambling age

There were significant age effects in responses to the question “At what age do you think you are allowed to gamble”. The following responses were more likely to be given if the respondent was older: 18 ($t_{(df=2304)}=2.079, p<0.05$) and 16 ($t_{(df=2304)}=3.587, p<0.05$). Younger respondents were more likely to suggest that gambling was allowed at any age ($t_{(df=2304)}=3.587, p<0.05$).

5.3.3.4 Reasons for participation in gambling

There was a single age effect in responses to the question “Why do you think some people choose to gamble?” which was that those who suggested a reason could be boredom were more likely to be younger ($t_{(df=2464)}=4.837, p<0.05$).

5.3.3.5 Reasons for non-participation in gambling

There were significant age effects in responses to the question “Why do you think some people choose not to gamble?” Participants who were older were significantly more likely to say people do not gamble because it is a ‘sin’ ($t_{(df=2470)}=2.127, p<0.05$); those

who were younger were more likely to say that people do not gamble because they are unlikely to win ($t_{(df=2470)}=2.987, p<0.05$).

5.3.3.6 Perceptions about those who gamble

There were significant age effects in responses to the question “What do you think about people who gamble?” The response ‘I feel sorry for them’ was more likely to be given if the participant was younger ($t_{(df=2314)}=3.367, p<0.05$). Older participants were more likely to say that they thought gambling is an individual’s choice ($t_{(df=2315)}=3.358, p<0.05$); that gamblers are exciting people ($t_{(df=2315)}=5.677, p<0.05$); and that gamblers are rich ($t_{(df=2315)}=4.707, p<0.05$).

5.3.3.7 Consequences of gambling

There were significant age effects in responses to the question “What might be some of the problems that could happen as a result of gambling?” Younger respondents were more likely than older respondents to identify the loss of money or possessions (e.g., house, car) as consequences of gambling ($t_{(df=2490)}=3.156, p<0.05$). Older respondents were more likely than younger respondents to identify the following as consequences of gambling: addiction ($t_{(df=2490)}=2.610, p<0.05$); getting into debt ($t_{(df=2490)}=7.056, p<0.05$); behavioural and/or emotional problems ($t_{(df=2490)}=4.391, p<0.05$).

5.3.3.8 Indicators of problem gambling in a friend

There were significant age effects in responses to the question “How would you know if a friend had a problem with their gambling?” Younger respondents were more likely to say they could spot a problem if their friends were rich ($t_{(df=2304)}=2.497, p<0.05$), or to say that they wouldn’t know ($t_{(df=2304)}=3.605, p<0.05$). Older respondents were more likely to say that an indication of having a problem may be spending all their money at once ($t_{(df=2304)}=0.718, p<0.05$) or committing a crime ($t_{(df=2304)}=4.671, p<0.05$).

5.3.3.9 Helping Behaviour

There were age effects in responses given for the question “What could you do to help a friend who had a problem with their gambling?” Respondents who were older were more likely to say that they would talk to them ($t_{(df=2240)}=3.534, p<0.05$), direct them to treatment ($t_{(df=2240)}=4.985, p<0.05$), or say that they didn’t know what they would do ($t_{(df=2240)}=2.858, p<0.05$). Younger respondents were more likely to say that they would keep them away from gambling premises or activities ($t_{(df=2240)}=5.108, p<0.05$).

5.3.3.10 Any other thoughts on gambling

There was one significant age effect found in response to the question “Anything else you wish to say about gambling?” Older respondents were significantly more likely to say that gambling was good or cool ($t_{(df=2240)}=2.858, p<0.05$)

5.4 Discussion

The aim of this study was to explore the types of issues that young people feel are pertinent to gambling, such as perceptions of gambling and gamblers, motivations to engage in gambling behaviour, problem gambling in terms of knowledge, indicators and consequences, and most importantly how young people might recognise signs of gambling problems in their peers and encourage them to seek treatment should they need it.

5.4.1 Knowledge about Gambling

Young people appear to have a reasonable breadth of knowledge about gambling. The types of gambling identified by the participants in this study (poker; non-poker card games; bookmakers; horse racing; dog racing; sports betting; casino gambling; roulette; slot machines; lotteries; scratchcards; bingo; internet gambling; arcade gambling) broadly match those available in Great Britain (Wardle et al, 2011). Unsurprisingly,

respondents did not identify spread betting as a distinct form of gambling, nor did they suggest football pools, however this may have been encompassed by the category 'sports betting'. Interestingly young people did not identify 'private betting', unregulated betting amongst friends, as a type of gambling. It may be that they did not distinguish between regulated and unregulated gambling; they may have classed betting on a football match with friends under the category 'sports betting'. However this could also be an indication that young people do not perceive informal or private betting as 'real' gambling. This has important implications within this age group as informal gambling is the second most commonly participated in form of gambling amongst adolescents, after slot machine play (Ipsos MORI, 2009), with 10% of young people partaking in this activity each week. If they do not view it as 'real' gambling any harm which may be related with the behaviour may be minimised or not recognised.

Awareness of the legal age at which an individual can gamble was low, with 62% of participants suggesting it was 18 years of age, and just under one in five (19%) saying that the legal age is 18 but 16 to play the national lottery. One in every 20 adolescents knew that gambling is available at any age, and those that said this tended to be younger. However we cannot read too much into this figure, as given the ambiguous wording of the question this could mean that this suggested that either these respondents knew that certain forms of gambling (e.g. games in Family Entertainment Centres) could be played by anyone regardless of age, or could equally mean that they thought all forms of gambling were open to anyone.

5.4.2 Perceptions of Gamblers

The findings regarding the perceptions of young people about why people may or may not choose to gamble suggest that they think that money is important in motivation for

the behaviour. Almost 70% of respondents thought that people gamble to win money; the next most common response was for fun or enjoyment with only 20% of respondents suggesting this. Money was also an important factor in reasons not to gamble; 55% of respondents said that avoiding debt was a major reason not to gamble. Interestingly, females and younger respondents were more likely to say that people gambled because they were bored. Despite there being few participants (9%) who gave this response this may indicate that boredom is an important motivation for young girls to gamble. Younger males were more likely to feel sorry for gamblers, and older males were more likely to think they must be rich. Older respondents were also more likely to think that gambling is an individual choice that should not concern others, and to think that gamblers are exciting. This may be suggestive of increasing tolerance of gambling behaviour as age increases.

5.4.3 Consequences of Gambling and Identifying Problem Gambling

Unsurprisingly, the most common responses regarding the consequences of gambling were financial – the loss of money and/or possessions (58%), and debt (35%). Younger respondents were more likely to report loss of money/possessions whereas older adolescents were more likely to suggest debt, addiction and behavioural, emotional or alcohol problems. This may be an indication of a growing awareness of social problems during adolescence. However only 8% of respondents suggested behavioural and/or emotional problems as a consequence of problem gambling and only 10% suggested relationship problems. Females were more likely to suggest behavioural, emotional and alcohol problems which may be an indication of increased emotional awareness in female adolescents when compared with males. Interestingly, males were more likely to identify arguably more serious consequences of gambling behaviour: crime and death.

In terms of indicators of problem gambling in a friend, respondents gave answers which indicated a limited amount of knowledge about how gambling problems may manifest. Participants were most likely to cite financial issues (having no money/possessions, 46%; borrowing money, 16%) and gambling frequently (34%). This is unsurprising given that money is intrinsically associated with gambling. Females were more likely to suggest gambling all the time and having no money or possessions as indicators of having a gambling problem. Males were more likely to think that they would be able to tell if their friend had a gambling problem if they were rich, spent all their money at once or were involved in crime. Males and younger respondents were also more likely to say that they would not be able to tell if a friend had a gambling problem.

The responses given as indicators of gambling problems relate to the following criteria from the DSM-IV diagnostic criteria (APA, 1994): Preoccupation (talking about gambling often; gambling all the time); Withdrawal and loss of control (Spending everything at once; Having no money/possessions); Illegal acts (crime); Family or job disruption (Emotional or behavioural changes); and Financial bailout (borrowing money). Criteria which, unsurprisingly, were not identified by any of the respondents were: Progression (becoming more preoccupied with reliving past gambling experiences, studying a gambling system, planning the next gambling venture, or thinking of ways to get money), Tolerance (having to gamble with more and more money to get the same level of excitement); Escape; Chasing; and Deception. Criteria which were not given as indicators of problem gambling may provide useful areas for awareness raising and education within this age group, as they are unlikely to be aware of these as potential indicators of harm. This is particularly true for chasing behaviour, which involves spending more and more money to try and win back losses. This has been argued to be a major indicator of problem gambling and identifying and trying to

change this behaviour may be a useful intervention in early problem gambling development. Less than 10% of the respondents cited behavioural or emotional changes as indicators of problem gambling. Given that behavioural and emotional changes are intrinsically associated with problem gambling (Bland, Newman, Orn et al, 1993; Dickson, Derevensky & Gupta, 2002; Gupta & Derevensky, 2000; TACADE/IGRU, 2007) it seems that adolescents may need further education around these issues. This education might usefully start at the younger end of the age group, given that younger respondents were less likely to know how to spot gambling problems.

5.4.4 Helping a Problem Gambler

There was a wide range of helping strategies suggested by participants, with the most common response being to talk to their friend (31%), which was more likely to be cited by older females. The next most common response was to keep their friend away from gambling premises and activities (21%) and this was most likely to be cited by younger males. Surprisingly, only 1% of respondents reported that they would tell an authority figure, for example, a parent, teacher or school nurse, about a friend's gambling problem. Nineteen percent suggested that they would try and direct a friend toward some type of gambling treatment – again there were significant age and gender effects in that older females were more likely to suggest this. The most common types of treatment suggested were telephone help lines, GPs, or counsellors. This may suggest that adolescents need further education surrounding the types of treatment available to them, in particular help that young people may find more accessible and appropriate, such as internet-based help forums.

A worrying finding was that many young people would employ implausible or unhelpful helping strategies, such as lending the gambler money, being violent towards

them, or keeping them away from gambling venues and activities (which would be difficult for someone, particularly an adolescent, to do 24 hours a day, 7 days a week). A small number of respondents (5%) also said that they would either be unable, or would not know how to help someone with a gambling problem, which together with the other findings indicates a need for education regarding appropriate treatment or help available, or encouragement to discuss such problems with other people who can help.

This study gives a useful indication of the kinds of issues that adolescents feel are relevant to gambling and problem gambling, and in particular allows us to ascertain what types of helping behaviour they feel are appropriate and/or available for them and their peers. This is relevant to the aims of this thesis, which are to identify barriers to treatment seeking among adolescents and young adults in the UK, and will engender an understanding of what this age group know about problem gambling and its treatment, and more importantly, what they would actually do if faced with a friend with a gambling problem. This will inform the remainder of this thesis: without an understanding of these fundamental issues important research directions could be overlooked.

5.4.5 Limitations

There were a number of limitations to the present study. Given that this was a secondary analysis of an existing dataset, there were limitations in both the design and the implementation of the study for the purposes of illuminating this area. Firstly, the age of participants included a small number of young adults. Given that the study aimed to explore adolescent gambling behaviour and attitudes having some participants aged over 18 may have caused problems. However it was decided that these participants should be left in the analysis, as the educational facilities targeted included a small

number of facilities for those not in mainstream education, and therefore participants were still in educational settings providing a curriculum aimed at those under the age of 18.

The demographic data collected by the questionnaire was also limited. The only demographic data collected concerned age and gender, therefore the study was unable to identify whether knowledge about gambling and the impact of problem gambling differs among different socio-economic groups. This may have been useful when considering developing targeted education and is something that should be considered as part of the wider research programme. However, the questionnaire was administered to a large sample and participants came from a wide variety of educational backgrounds, from pupil referral units to grammar schools across the United Kingdom. It can therefore be assumed that the results are indicative of attitudes held by adolescents from different socio-economic backgrounds, despite the fact that these data were not collected as part of the survey.

A major limitation of this research was that it did not ask any questions about the level of experience of gambling and problem gambling that the respondents had. For example, it may have been useful to examine the differences in responses from those who do not know anyone who gambles with those who do know someone and/or who gamble themselves, or those who would classify themselves or someone they know as a problem gambler, as these categories may go some way to explaining the age effects found. It is likely that the older a respondent, the more likely they are to be more familiar with gambling.

5.4.6 Further Work

Some of the most interesting data to come from this study surrounded what adolescents would do to help a friend with a gambling problem. Less than one in five respondents would direct a friend towards treatment. Further research should investigate this issue. Is this due to a lack of awareness of gambling treatment available? Is it because problem gambling is not considered significant enough to warrant treatment? Is it a question of privacy for their friend? Is this ultimately how they would wish their friends to help them if they developed a problem? Research is needed on what treatment adolescents would find most useful. This study also found that only one person out of every hundred would tell someone else who may help if a friend developed a problem with gambling. This could be out of respect for privacy but may also be an indication that it is not viewed as a serious problem. Reasons for this finding need further research in order to begin to develop a helping culture that may ultimately lead to more young people seeking treatment for gambling problems if they need it.

In terms of indicators of problem gambling, it would be useful to ask whether adolescents and young people are more influenced by personal experience or the media with regards to developing this kind of knowledge. This is important, because the results suggest that the financial impact of gambling is the most commonly cited indicator of problem gambling. If this is something that adolescents are aware of through personal experience, it may be useful for education programmes to focus on the behavioural and emotional impacts, as these are commonly the most destructive aspects of gambling problems. Younger males were more likely than older males to suggest an indicator of problem gambling was being rich. This shows an inherent misunderstanding

of the concept and is something that may be due to the perception given in the media of gambling (i.e., glamorous casino gambling in films and on TV) and must be tackled.

5.4.7 Summary

Given the exploratory nature of this study it does not specifically answer any questions. In fact, as with much exploratory research it throws up more questions than it answers. These questions will be used during the remainder of the research programme to guide the development of interview schedules.

Chapter Six: Barriers to Treatment Access for Young Problem

Gamblers: A Qualitative Investigation

6.1 Introduction

Whilst for many people gambling is an enjoyable, recreational pastime, for a significant minority it can become addictive and difficult to control. While we do not fully understand the reasons why certain people develop problems and/or become addicted to gambling, we do know that it is likely to be due to a combination of psychological, social, and biological reasons (Griffiths & Delfabbro, 2001; Marlatt, Curry, & Gordon, 1988). Some groups are more vulnerable to developing gambling problems than others, such as ethnic minorities, and those from socioeconomically deprived backgrounds (Sproston, Erens, & Orford, 2000), and one of these groups appears to be young people. To understand the problem we should first look at rates of participation in gambling, rates of problem gambling, and identify the negative effects of problem gambling.

The UK has high rates of gambling participation in comparison to other jurisdictions (Powell & Tapp, 2009). Almost three quarters of the adult population in Great Britain (72%) has participated in some form of gambling in the past year (Wardle et al, 2011). Despite this, the UK has one of the lowest rates of problem gambling in the developed world with only 0.9% of the population currently a problem gambler, as defined by the DSM-IV criteria (Wardle et al, 2011). This is slightly higher than the prevalence rate found in the previous 1999 and 2007 British Gambling Prevalence surveys (Sproston et al, 2000; Wardle et al, 2007) indicating a somewhat stable picture in the UK. However, this is currently a period of regulatory change: the introduction of the Gambling Act (2005) has led to wider accessibility of some forms of gambling and also allows for the advertisement of gambling products on television and radio. The cohorts examined in

the most recent prevalence studies grew up when gambling was less normalised and accessible as it is today (Jacobs, 2000; Shaffer & Hall, 1996; Stinchfield & Winters, 1998; Welte, Barnes, Tidwell & Hoffman, 2008). It has also been asserted that alongside the growth in access to, and use of, the internet, the number of those gambling online is likely to increase in the future, and this concern is contributed to by the fact that it is particularly difficult to 'police' underage gambling online (Powell & Tapp, 2009). This may have implications for the younger generations, as adult prevalence studies conducted in the future may begin to show higher rates of gambling and problem gambling as today's cohort of youth grow older. It has been demonstrated that Rose's (1985) single distribution theory applies in the context of gambling (Grun & McKeigue, 2000). This theory advocates that as with any characteristic proportionally distributed in the population (in this case problem gambling), the proportion of problem gamblers in the tail of the population distribution depends upon the average level of gambling behaviour as a whole (Rose, 1985). If this theory applies, it may have important implications for public health in the UK. Some of the problems associated with problem gambling include suicide, domestic violence, and crime (Bland, Newman, Orn, & Stebelsky, 1993), in addition to wider social and economic problems such as emotional, marital, financial, and/or workplace problems for both problem gamblers, and their friends, family, and colleagues (Productivity Commission, 1999).

6.1.1 Problem Gambling in Young People

Gambling is an activity undertaken by individuals from a wide range of population subgroups, irrespective of age, sex or race. Despite legislative efforts to prevent the participation in many forms of regulated gambling by children and adolescents (such as minimum age restrictions on participation in some gambling activities), there is much empirical evidence that youth continue to engage in both regulated and non-regulated

forms of gambling (Derevensky & Gupta, 2004). 72% of adults are reported to have taken part in gambling activities in the past year in the UK (Wardle et al, 2011). This is comparable with international prevalence studies which have found that between 60% and 80% of young people have taken part in a gambling activity within the past year (Derevensky, Gupta, Dickson, & Deguire, 2004; National Research Council 1999). The most recent research looking at the prevalence of youth gambling and problem gambling in the UK (Ipsos MORI, 2009) identified that 21% of 11-15 year olds have gambled within the last week. The majority of adolescents who take part in gambling activities do so without experiencing significant negative effect. However, 2% of adolescents are estimated to have a gambling problem. This is more than twice as high as the problem gambling rate found in adults (Wardle et al, 2011), and shows that young people may be particularly susceptible to developing gambling problems. However, it has been estimated outside the UK that between 3% and 8% of adolescents have a gambling problem, with a further 10% to 15% being 'at risk' for developing a gambling problem (Derevensky & Gupta, 2007). It seems that the context of gambling in the UK may have some protective factors against the development of gambling problems, due to the high levels of participation but relatively low levels of pathology.

As previously noted, problem gambling can cause a significant number of social and emotional problems, not just for the problem gambler but also for the family, friends and colleagues of those affected (Productivity Commission, 1999). However, for young people, these problems are slightly different as they are not as likely to have mortgages, careers, and/or spouses due to their age. In addition to the problems associated with excessive gambling generally, there are a number of problems that may particularly affect adolescents. In terms of mental health, adolescent gambling has been associated with major depression, anxiety, ADHD, low self-esteem, and personality disorders

(Dickson, Derevensky, & Gupta, 2002; Fong, 2006; Gupta, & Derevensky, 2000). Young problem gamblers are also more likely to be involved in alcohol and substance abuse, theft, truancy, and exhibit poor educational performance (Griffiths, Wood & Parke, 2007). Male adolescents are more likely to engage in problem gambling behaviours compared to female adolescents (Abbott, Volberg, Bellringer, & Reith, 2004; Derevensky & Gupta, 2004, National Research Council, 1999). However, females are still affected. In terms of ethnicity, while Asian children are no more likely to gamble than those from other ethnic backgrounds, they have been shown to be more likely to be problem gamblers, highlighting the need for cultural issues to be researched further (IPSOS Mori, 2009).

So why are young people particularly at risk for developing gambling problems? Youth has been typified as a time of general excess, and literature has identified that many adolescents experiment with risky behaviours such as the consumption of alcohol and drugs, risky sexual behaviour, risky driving, and crime (Klein, Brown, Dykers, Childers, Olivieri, & Porter, 1992). Adolescents may mature out of such risk taking behaviours, however, many do not follow this path (Irwin & Millstein, 1986; Irwin, 1990). Adolescence is a time of testing boundaries, and young people tend to indulge in more risky behaviours as part of the development process (Prus, 2004) They may also engage with gambling behaviour due to peer pressure, wanting to 'trying it out', perhaps following the lead of family members (Gerdner & Svensson, 2003; Wood & Griffiths, 1998; Wood & Griffiths, 2004)

Young people participate in gambling more so than they do in any other addictive behaviour (Gupta & Derevensky, 1998), and are likely to start participating in gambling behaviours earlier than other risky behaviours such as cigarette smoking and substance

abuse (Stinchfield, 2004). This is worrying because younger people have been shown to be at a higher risk for developing problems related to their gambling behaviour as they are often introduced to the activity by family and friends who portray it as a harmless activity and possibly have their own gambling addiction (Gupta & Derevensky, 2004, Jacobs, 2000). It has been repeatedly shown that parental gambling is a correlate of gambling behaviour (Becoña, Labrador, Echeburua, Ochoa, & Vallejo, 1995; Delfabbro et al, 2005; Felsher et al 2003; Gambino, Fitzgerald, Shaffer, Renner, & Courtnage, 1993; Gupta & Derevensky, 1997; Jacobs, 2000; Ladouceur & Mireault, 1998; Winters, Stinchfield & Kim, 1995; Wood & Griffiths, 1998). Many adult problem gamblers began their gambling careers in their youth, began gambling at home, and report experience of parental and familial gambling. Often, problem gamblers have had an early experience of a 'big win' (Griffiths, 1995). Adolescent problem gamblers have also been shown to hold a more positive attitude towards gambling (Gillespie et al 2007), have poorer coping skills (Gupta, Derevensky & Maget, 2004), and exhibit more erroneous beliefs regarding luck and perceived skill (Derevensky et al, 1996; Wood & Griffiths, 2002). However, there is a lack of longitudinal research and no robust evidence about the causes of problem gambling behaviour.

The tolerance of family and friends also makes it easier for young people to gain access to gambling activities. The role of family is particularly important. For instance, Ladouceur et al, (1998) found that only 5% of parents would try and stop their child from partaking in gambling behaviour. It has also been shown that only 2% of adolescents ever gamble alone, whereas 59% of adults always gamble alone (Valentine & Hughes, 2008). This has implications especially for explaining young people's access to restricted forms of gambling, as they may be relying on older friends and/or relatives as an access point to the activity.

It has been shown that some young people gamble as a means of coping and avoidance, but as their gambling becomes problematic, the more stresses they face and their need to gamble increases, thus creating a vicious circle whereby gambling behaviour is experienced as both a problem and a strategy for dealing with problems (Griffiths, Wood & Parke, 2007).

Young people have been shown to hold many erroneous beliefs with regards to the roles of superstition, luck, and probability. Although this is thought to contribute to the higher rates of problem gambling found in adolescents, it is important to note that traits are often found in adults too. While not all adolescent gamblers will end up developing a problem, the negative effects of gambling on adolescents are serious and warrant a sustained and directed approach to addressing the issues.

Attempts to tackle problem gambling in young people may be through means of prevention (i.e., awareness raising, education programmes, and/or via treatment). Treatment options available for problem gambling include psychotherapy, cognitive behavioural therapy, counselling therapy, group therapy, and pharmacological treatment (Petry, 2005). However there are few (if any) treatment options available specifically tailored to young people. Some young problem gamblers seek advice and counselling via generic youth services in the UK, however this arrangement is often ad hoc, managed locally and based upon local need and clinical interest of staff. Despite there being an array of treatment options available for adults, it has been suggested that relatively few problem gamblers seek help (Cunningham, 2005). This is also the case within the field of mental health in general, it is a common concern that many people who need help do not seek or receive it (Hornblow, Bushnell, Wells, Joyce & Oakley-Browne, 1990; Lin, Goering, Offord, Campbell, & Boyle, 1996). It is likely then that

young people, faced with the difficulties of seeking help in general and the lower levels of service provision available to them are extremely unlikely to seek help for gambling problems.

6.1.2 Summary of Literature on Barriers to Treatment Access

Specific barriers to treatment access for young problem gamblers have been covered in detail in Section 2.4 of this thesis. Table 13 provides a summary of these barriers and indicates where they have been discussed in the literature.

Table 13: Summary of literature on barriers to treatment access for problem gamblers.

Barrier	Description	Literature
Desire to handle problems alone/belief in ability to do so	Some problem gamblers believe that they will be able to handle their problems by themselves without having to seek additional help or support	Boughton & Brewster, 2002; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Nova Scotia Department of Health, 2001; Pulford, Bellringer, Abbott, Clarke, Hodgins, & Williams, 2009; Tavares, Martins, Zilberman, & el-Guebaly, 2002; Tremayne, Masterman-Smith, & McMillen, 2001
Shame, secrecy, embarrassment, pride and fear of stigma	Such feelings may stop problem gamblers from admitting that they need help	Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002
Denial	An unwillingness to admit or a minimisation of the problems associated with gambling	ACNielsen, 2007; Chevalier & Griffiths 2004*; Evans & Delfabbro, 2005; Griffiths 2001*; Hodgins & el-Guebaly, 2000; Ladouceur et al., 2004*; Nett & Schatzmann, 2005; Pulford et al, 2009
Treatment concerns	Concern about what goes on in treatment or about its quality or efficacy/lack of knowledge about treatment options and practical issues around attending	Hodgins & el-Guebaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004
Social pressure to continue gambling, or socially constructed to be non-problematic:	Pressure from others within their personal social networks to continue gambling, or receiving a lack of support to make a change to their behaviour	Chevalier & Griffiths 2004*; Griffiths 2001*; Piquette-Tomei, Dwyer, Norman, McCaslin, & Burnet, 2007; Pulford et al, 2009

Barrier	Description	Literature
Benefits of gambling a strong draw	Do not want to stop or to give up the financial, social or emotional benefits of gambling	Boughton & Brewster, 2002; Chevalier & Griffiths 2004*; Evans & Delfabbro, 2005; Griffiths 2001*; Tavares et al, 2002;
Difficulty talking about the problem	Significant difficulty in sharing problems or talking about personal issues	Boughton & Brewster, 2002; Cooper, 2001, 2004; Hodgins & el-Guebaly, 2000; Rockloff & Sheffield, 2004
Not reaching financial crisis	Reaching ‘rock bottom’ is an important factor in seeking help, and not something that often occurs in young people due to bailout and the lack of significant amounts of money, possessions (e.g., a home) or relationships (e.g., spouse and children) to lose	Abbott, 2001; Downs & Woolrich, 2009; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; McMillen et al, 2004
Adolescents may not actually be aware of the severity of their gambling-related problem	This may be due to a high level of social acceptability of gambling, combined with a lack of awareness of the possible harms associated with gambling.	Gupta and Derevensky, 2000*; Hardoon, Gupta and Derevensky, 2003*

Barrier	Description	Literature
Adolescents may fail to recognize that they have a gambling addiction until their problems are relatively severe (e.g., legal actions pending against them, loss of friends, etc.).	By the time young people are willing to seek treatment for a gambling problem they are usually experiencing significant family, social, academic, and legal difficulties	Gupta and Derevensky, 2000*
Spontaneous remission/maturing out	It may be that some young people 'grow out' of their gambling problem without outside help	Chevalier & Griffiths 2004*; Griffiths 2001*
May commit suicide first	It may be that adolescent problems with gambling reach a crisis point before they are able to seek help	Chevalier & Griffiths 2004*; Griffiths 2001*
Adolescent excesses change too frequently to warrant treatment	It may be that some adolescents do not experience long term problems with their gambling behaviour as interests change	Chevalier & Griffiths 2004*; Griffiths 2001*
Adolescents don't seek treatment in general	Reluctance to seek help across age group	Chevalier & Griffiths 2004*; Griffiths 2001*

Barrier	Description	Literature
Adolescents may seek another form of treatment before getting treatment for gambling	Seek help for comorbid issues	Chevalier & Griffiths 2004*; Griffiths 2001*
Treating underlying problems may indirectly help gambling	May be seeking other help which indirectly helps with gambling behaviour	Chevalier & Griffiths 2004*; Griffiths 2001*
Negative consequences not unique to gambling	May not identify gambling as the cause for the negative consequences they experience	Chevalier & Griffiths 2004*; Griffiths 2001*
Bailout	(Parental) bailout can mask the problem	Chevalier & Griffiths 2004*; Griffiths 2001*
Lying or distortion on self-report measures**	Adolescents may not accurately represent their problem on screening tools	Chevalier & Griffiths 2004*; Griffiths 2001*
Measurement issues**	Possibility of invalid screening instruments for measuring problem / Screening instruments being used incorrectly	Chevalier & Griffiths 2004*; Griffiths 2001*; Stinchfield (1999)

Barrier	Description	Literature
May not understand what being asked**	Screening instruments being used incorrectly so participants are not sure what they are being asked	Chevalier & Griffiths 2004*; Griffiths 2001*
Lack of adolescent treatment programmes	There may not be a treatment service for them to access	Chevalier & Griffiths 2004*; Griffiths 2001*
Treatment programmes not being appropriate/suitable for adolescents	Treatment services may be unsuitable for their age group	Chevalier & Griffiths 2004*; Griffiths 2001*
Attending treatment programs may be stigmatising	May feel embarrassed, shame, stigma	Chevalier & Griffiths 2004*; Griffiths 2001*

* Reference looked specifically at issues in adolescents and young people

** Not necessarily a 'barrier' for treatment access but rather an explanation as to why academics may believe that the rate of treatment seeking in adolescent problem gamblers is low.

It should be noted that there are no empirical studies around barriers to problem gambling treatment access that highlight the issue from a treatment professional point of view, and only one from a young problem gambler's point of view (Ladouceur et al 2004) however this study selected its sample based on knowing someone with a gambling problem, rather than based on having a gambling problem themselves.

Treatment providers and young problem gamblers are likely to be the primary informants about the reasons why young people tend not to access treatment for gambling problems. Therefore, the aims of the following two studies were to: examine the views of clinicians involved in the treatment of problem gambling who have had some experience working with young people, to explore why young problem gambling may be unable and/or unwilling to access treatment for their problem; and to examine the views of young problem gamblers themselves about why they have not sought treatment for their problem.

6.2 Study 3a: Barriers to Treatment Access for Young Problem Gamblers: Treatment Providers' Perspectives

6.2.1 Method

6.2.1.1 Participants

Practitioners who specialised in the treatment of problem gambling from a range of different types of treatment centres were approached to participate in this study. This included those working at (i) the only national residential centre which specifically treats problem gambling, (ii) a national problem gambling treatment charity that has a national helpline and a walk-in counselling service, (iii) the only National Health Service run problem gambling treatment centre, and (iv) those that worked in other settings (e.g., cognitive behavioural therapists, private counsellors). For the purposes of this chapter, all the practitioners interviewed are referred to as 'clinicians'. Eleven individuals were

selected to take part in the study based on the criteria that they were currently working within the problem gambling field, and that they had previous experience of working with young people around gambling problems, either directly or indirectly within a treatment service. The settings in which they worked were residential problem gambling treatment centres (n=4), multi-modal problem gambling treatment centres (e.g., offering telephone counselling, web-based support and face-to-face counselling) (n=3), National Health Service (n=2), and private counselling settings (n=2). Table 14 gives further information about the specialism and experience of each participant.

Table 14: Specialism and experience of clinicians

Clinician	Current role	Length of service	Type of help offered	Experience with different client groups
1	Residential service provider	4 years	Counselling/support	Youth Adult Residential
2	Residential service provider	11 years in treatment, 6 years previous in academia	Counselling/support	Youth Adult Residential Particular interest in treatment of women
3	Residential service provider	10 years	Counselling/support	Youth Adult Residential Online
4	Residential service provider	3 years	Counselling/support	Youth Adult Online
5	Private counsellor	8 years	Counselling	16+ face to face
6	Multi-modal	6 years	Counselling	Youth Adult Telephone helpline, online, and face to face
7	Multi-modal	1 year	Counselling	Youth Adult Online and face to face

8	Multi-modal	12 years	Counselling	Youth Adult
9	NHS Psychiatrist	9 years	Psychiatrist	Youth Adult Addictions specialist
10	NHS CBT therapist	18 years	CBT	Youth Adult
11	Private counsellor	4 years	Counselling	Youth Adult

6.2.1.2 Materials

6.2.1.2.1 Interview schedule

A flexible, open-ended interview schedule was devised comprising of a number of topics relevant to the aims of the research surrounding the clinician's perspectives on barriers to treatment access for young problem gamblers. The main topics that were discussed are outlined in Figure 8. All interviews were recorded using a digital recording device and field notes were taken to aid later analysis.

Figure 8: Interview Schedule – Clinicians

1. The clinician's role in the treatment of problem gambling
 - a. Length of service
 - b. Type of help offered
 - c. Experience with different client groups
 - d. Current role
2. Specific experience with young people
 - a. Any problems with treatment take up
 - b. Number of clients seen in this age group (comparison with other age groups)
 - c. Main problems in the age group – what gambling on/what impact
 - d. How do they arrive there – relatives/self-referral...motivation?
 - e. Type of help offered – does it work? If not, what might?
 - f. Abstinence/control
 - g. Age specific treatments?
 - h. Experience of this age groups ability to engage with treatment
 - i. Specific difficulties in working with this age group
 - j. Most effective treatments (e.g. therapy/modality-face-to-face,online,helpline/peers-mentors)
 - k. Attendance/Dropout/Participation
 - l. Role of family/friends/mentors
 - i. Do they know
 - ii. Kind of support?
 - iii. Reaction/impact on treatment
3. Differences in working with this age group and other clients
 - a. Difficulties
 - b. Advantages
4. Barriers for young people to access treatments they provide
 - a. If only see older, why have they come now?
5. Ways which may help young people overcome these barriers
 - a. Govt policy
 - b. Advertising
 - c. Schools/education

6.2.1.3 Procedure

All participants were interviewed via either a face-to-face-interview at their place of work or via telephone interview where the participants schedule was too busy to arrange a face-to-face meeting. Participants were asked to read information about the study that detailed what would be asked throughout the interview and how the data were going to be used. Participants were assured that their responses would remain anonymous, but that their words may be reported verbatim in any written outputs in order to highlight the themes that came out of the analysis. All participants signed a consent form for taking part in the

research. Interviews ranged from 34 minutes to 80 minutes, and were recorded using a digital recorder. The interviews were then transcribed verbatim for use in data analysis.

6.2.1.4 Data analysis

Interviews were transcribed verbatim, and the resulting transcripts were analysed using a data-driven thematic analysis procedure outlined by Boyatzis (1998) and Braun and Clarke, (2001). For further description of this method see Chapter 3, Section 3.3.3.2. In Stage 1, responses to each question in a small selection of transcripts were read several times, and key words were noted as a means of reducing the raw data into categories. Themes were developed from the key words, to ensure saturation of data and identify themes that may be specific to individual questions. In Stage 2, data were examined for similarity of themes. Similar themes and their responses were grouped together in categories. At this stage, the interview transcripts were re-checked to ensure that responses had been ascribed to appropriate themes, and similar groups of themes were assigned broader category titles.

6.2.2 Results

During the course of the eleven interviews, participants described their experiences of treating people with gambling problems and their specific experiences of working with young problem gamblers. They reflected on the differences between working with young problem gamblers and older clients, and suggested reasons as to why it may be difficult for young people to come forward and engage with treatment services for problem gambling. All participants agreed that there were specific barriers to treatment access within the younger population, and suggested ways in which these difficulties might be overcome.

There were four main themes that emerged during the analytic process. Each category held a number of similar subthemes of ideas about barriers to problem gambling treatment access. The main themes were ‘Client-Centred Barriers’; ‘Clinician-Centred Barriers’; ‘Environmental Barriers’; and ‘Motivational Barriers’ (see Figure 9). Each theme and its related subthemes are described in detail below.

Figure 9: Emergent Categories

<i>Emergent Categories</i>	
Clinician-Centred Barriers	Lack of skills
	Lack of empowerment
Environmental barriers	Societal awareness
	Specifically tailored services
Motivational barriers	Point of Referral
	Peer Ambivalence and Peer Pressure
	Role of Family and Culture
	Bail Out
Client-centred barriers	Emotional Immaturity and Poor Verbal Communication Skills
	Lack of Awareness about Problem Gambling
	Stigma about Help-Seeking and Mental Health Issues
	Denial
	Unrealistic Treatment Expectation and Dropout
	Adolescence as a Time of Excess
	Gambling as a Secondary Issue
Lack of Life Experience	

6.2.2.1 Client-Centred Barriers

Many clinicians felt that young problem gamblers often display intrinsic factors which are common to the personalities and abilities of young people in general, that may hinder their ability or desire to access treatment for a gambling problem. There was a sense that younger people are less well equipped to communicate with others about their problems, that there was a lack of awareness about problem gambling, and that stigma and denial

play a large role in delaying young problem gamblers help-seeking. Being younger may also mean that there are a range of other issues which also need to be dealt with which may in fact mask the need for treatment for problem gambling. Young problem gamblers may also not know what to expect from problem gambling services.

6.2.2.1.1 Emotional Immaturity and Poor Verbal Communication Skills

Younger people were perceived to have a lower level of emotional maturity and a poorer ability to verbally communicate, particularly around emotional issues. This was thought to be in part due to the fact that socialisation amongst young people in general may not tend to facilitate good communication skills.

“Emotional literacy and life experience is not as far developed, it’s almost as though they don’t have the vocabulary.”

“Teenagers don’t communicate very well. If you ever think of adolescent lads...they don’t engage in conversation”

The lack of verbal communication problems was perceived to be more of a problem for males than females. It was suggested that young people may feel uncomfortable in a treatment setting due to their lack of verbal ability. Often being able to articulate thoughts and feelings on an issue is intrinsic to the types of treatment offered for problem gambling (Petry, 2005), and as such a lack of verbal ability would be a significant barrier to seeking help.

“Self-consciousness about being inarticulate and unable to expand is a big problem”

It was suggested that a lack of emotional maturity was a particular problem for young males accessing problem gambling treatment services. It was suggested that this would lead to a variety of difficulties with accepting that there was a problem, asking for help, and/or for accessing a treatment service.

“Young men are less likely to be emotionally mature than their female counterparts”

Whilst these notions could be applied to any young person, young people with gambling problems were thought to be significantly poorer in emotional maturity and emotional literacy than their peers, due to the effect that problem gambling has on normal social development.

“They age chronologically but aspects of their psycho-socio-emotional development never take place because they don’t go through adolescence..... Relationship skills, relationship building, getting work, all those things don’t happen.”

A possible reason for the poorer communication skills held by young problem gamblers may be a direct result of them spending more time alone in the gambling environment rather than socially interacting with their peers and/or others. For instance:

“So you know if you spend your whole life in the bookies, or, I don’t know, an arcade, you are not interacting with other adults and you know growing up they tend to be very immature so if you have got an 18 to sort of 21 year old coming into [the treatment centre] then generally speaking they are going to have the mental age of a twelve-year old, very, very immature.”

Problems with verbal communication which are common amongst young people may affect both entry into treatment, but also cause problems, and perhaps drop out, if the individual had actually started a treatment programme.

“They haven’t had proper girlfriends or other adult friends so they find it very difficult to communicate and which is why very often they don’t come for treatment, because coming for treatment is a very grown up thing to do, its saying that I have got a problem and I need to talk about it. Well, twelve-year olds don’t talk, you know”

6.2.2.1.2 Lack of Awareness about Problem Gambling

It was perceived that a lack of awareness about mental health issues in general and problem gambling in particular was an issue for young problem gamblers and their peers,

and was thought to play a role in the unwillingness of young people to discuss problem gambling and to seek help.

“It is not something that is talked about on the radio or in schools. You don’t talk about gambling in schools do you especially?”

Again this was considered to be a more salient issue for young males who may be less able to discuss their problems with their peers due to the lack of awareness or discussion about gambling as a mental health issue.

“I think lads in particular are at a disadvantage because men aren’t allowed to talk about feelings, it’s not, it’s just not done, so you grow up not talking about feelings and if you are a very emotional person and very sad, very upset and lonely, its difficult, especially for a young person, the group you are looking at, is very difficult for 17-year old lads really struggling for gambling or whatever reason to actually talk to his friends and say ‘I’m really upset, really lonely, I’m really frightened’ because you know, lads don’t do that.”

6.2.2.1.3 Stigma about help-seeking and mental health issues

Young people were perceived to be less likely than those of any other age to admit to having a gambling problem. It was suggested that this may be due to the stigma felt by young people when talking about mental health issues. This may be due to the magnified interest in what a young person does that they receive from their peers.

“There’s such a stigma when you are that age, you don’t want help”

One clinician generalised that young people were much less likely than someone older to admit either to themselves or to someone else, that they need help.

“The last thing a young person will do is admit they have a problem”

6.2.2.1.4 Lack of life experience

It was commonly suggested that people who seek treatment for a gambling problem do so because they are on the verge of, or have already, lost everything, and the consequences of their gambling behaviour have become very serious. For example, this may mean marriage breakdown, and/or losing a job or a home. For young people, the consequences of their gambling behaviour are likely to be less severe as they are less likely to have jobs, homes, and/or relationships with spouses and children to jeopardise. It was perceived that young people would be less likely to present themselves for treatment because they have not yet encountered the experiences of hitting ‘rock bottom’.

“It’s the addiction itself, I guess, like any addiction. Before you can even start looking at it, you have to admit that you have a problem and you need to really want to stop it, and very often with youngsters it hasn’t got to a stage where they have lost everything.”

“They have no responsibility; a lot of the older ones have a mortgage, family.”

Similarly, it was suggested that young people were also much less likely to have had the amount of life experience necessary to fully understand that they were not likely to win in the long run if they continued to gamble, or what the consequences of continued gambling might be. One clinician stated that young people:

“...still have the dream that gambling will pay.”

6.2.2.1.5 Denial

It was perceived that younger people were more likely to deny they had a problem with excessive gambling and feel that people around them were worried about nothing. It was suggested that young people would not access treatment for a gambling problem because, in their view, their behaviour was not problematic to them.

“There is this challenge that they think everyone is making a big fuss over nothing”

“Everyone else has got the problem, usually. It’s not them who’s got the problem, it’s mum, you know, it’s dad, it’s school, it’s probation, it’s the coppers, it’s the social workers, it’s not me, I’m alright, if they’d just let me do what I want to do it wouldn’t be a problem, I ain’t got a problem, they’ve got the problem.”

6.2.2.1.6 Gambling is a secondary issue

It was perceived that gambling problems amongst young people are often a secondary problem, as a symptom rather than a cause of emotional issues. It was suggested that this requires a different approach, focusing on the wider aspects of emotional health, rather than treatment for the gambling problem specifically. For instance:

“Gambling is a symptom...of something else, a way of acting out difficult unresolved conflict”

6.2.2.1.7 Adolescence as a time of excess

It was noted that young people tend to go through a time of general excesses of behaviour, meaning that they tend to take a particular behaviour to its limit to see how far they can take it, and that they may mature out of the risky behaviour before the need to access treatment arises.

“Most adolescents will push boundaries but wise up, get fed up, friends change, but a minority take it to the extreme.”

6.2.2.1.8 Treatment expectations and drop out

It was suggested that importantly there are also barriers to completing treatment, with young people dropping out of treatment once they had already sought help and were being treated within a service. In terms of those who accessed treatment but subsequently dropped out, it was thought that often their expectations of treatment were unrealistic and

differ from what is actually provided. They tended to want something different for themselves from treatment.

“They want to get something specific out of it. They might not know what that is. It might just be someone to talk to, someone who’s there”

Younger people were perceived to want more transient help by nature, and it was difficult for young people to commit to something and ensure stability.

“They don’t have the same motivation for sticking with it. Today it’s a great big problem, tomorrow not such a problem.”

“...reliability, if they will turn up the next time”

“It’s very difficult for a young person to commit themselves to anything to have that stability”

6.2.2.2 Clinician-Centred Barriers

Reflecting upon their work with young problem gamblers allowed clinicians to suggest barriers which may be within their control or remit, rather than barriers which were client-centred. Two main issues arose, namely a lack of particular skills thought to be important when working with young people, and a lack of empowerment (for themselves or others) to change the structure of their work to suit the needs of younger clients.

6.2.2.2.1 Lack of skills

It was perceived that there may be intrinsic characteristics of clinicians’ working style, and professional preferences and capabilities that prevented or deterred them from working with young people. One clinician highlighted that they felt it was:

“Much harder to work with young people. Young clients aren’t as expansive... with younger clientsyou give them a prompt and you get a quick succinct response and it can end up like a tennis match....it takes a lot to encourage them to reflect and expand, it’s much harder work, much more testing”

It was also suggested that clinicians needed to substantively alter the way in which they would work with a young person being offered treatment for a gambling problem. For instance:

“There are techniques I would use with older clients that I hold back from with younger clients, like challenge...it has to be dealt with extremely sensitively.”

The inhibition and awkwardness felt by a young person also caused difficulties for the counsellor in a therapeutic relationship:

“They tend to feel on the spot, that something is expected of them...there is a much greater onus on the counsellor to make them feel comfortable”

It appears that a particular set of specialist skills and knowledge are required to work effectively with young problem gamblers, which may impact upon the services made available to these clients.

6.2.2.2.2 Lack of empowerment

One clinician pointed out that although it is tempting to take on a guidance role with a younger client, it was important to try and maintain an equal relationship, as a power imbalance may encourage a young person to accept little responsibility for their own actions. For instance:

“Fathering them doesn’t help, it takes away their responsibility. “

In terms of what kind of treatment models work with young people, task-oriented and one-to-one work was thought to be most effective.

“What’s very effective with teenagers is CBT [cognitive-behavioural therapy] stuff, creating scales, keeping diaries”

“I think that with younger people ... the real work you can do is on a one-to-one level”

This is likely to be problematic within services which may only offer group sessions to younger clients or who work with a different model than CBT.

6.2.2.3 Motivational Barriers

A number of subthemes arose which were concerned with motivation to access treatment services. This theme concerned the external influences that young people may feel which may act as motivational barriers to help-seeking for their gambling problem.

6.2.2.3.1 Point of referral

It was perceived that young people have a different experience of treatment and desire or obtain different treatment outcomes, depending upon their motivation for being referred. Often, young people enter treatment for gambling problems at the insistence of a parent or through the probation system.

“the youngsters that tend to come in isn’t because they have suddenly woke up one day and said ‘I have got a problem I need to deal with this’. No it’s because mum and dad have grabbed them by the scruff of the neck and dragged them there, so the guys that don’t come in until their 40s it’s because mum and dad didn’t drag them here when they were 18 or 19.”

Not having this pressure to obtain treatment may indeed lead to not seeking help until later in life but may also contribute to non-engagement with services or treatment drop out.

“Rebelliousness that feeds through, if you feel pressured to do it by a parent or professional there is a cultural resistance.”

One treatment centre required that the problem gambler made self-referrals, to try and combat this motivational issue. However it was reported that clinicians tended to find that even though the young problem gambler has self-referred, they usually are not doing it without some outside influence.

“They may say they are self-referred but you find there is a pressure on them from elsewhere”

6.2.2.3.2 Peer ambivalence and peer pressure

A further motivational barrier suggested by clinicians was the influence of peers on a young person’s likelihood of help-seeking. One clinician suggested that young problem gamblers tend to have a:

“Network of gambling people around them”

Another clinician suggested that when surrounded by older family members and friends in the wider culture where gambling activity is permitted and endorsed, they may have gamblers as role models and as such fail to identify that gambling to excess is a problem.

One clinician suggested that a young person may:

“Look up to gamblers. They are presented as normal, and it’s never seen as being a problem.”

Some went further and suggested that gambling behaviour can give individuals certain credibility within their peer group that may serve to further dissuade young people from seeking help for gambling problems.

“Certain status within the peer group...don’t see the seriousness”

“In some teenage groups, ending up in court is a status thing”

The ties to their social network may prevent young problem gamblers from considering entering residential treatment programmes more so than they would affect an older problem gambler.

“Speak to a young person and suggest spending nine months [in a residential setting].

They won’t do that will they? They have a life to live!”

6.2.2.3.3 Role of family and culture

The influence that family background may have on the ability of young people to seek help for a gambling problem was suggested during the interviews as an important barrier to accessing treatment. It was thought to be particularly important to educate families on the potentially detrimental consequences of involving young people in gambling activities.

“ It’s important to educate family. You’ll have dads who say ‘Which horse do you want son?’”

Potential cultural barriers to admitting to having a gambling problem were highlighted by one clinician who suggested that for many young people, asking for help could incur serious negative consequences.

“They may get shipped back to India or Pakistan or wherever. So they wouldn’t admit to having a problem.”

The positive influence that families can have on older problem gamblers was highlighted, showing again that because younger people do not risk losing these types of relationship through their gambling behaviour, they may not have the pressure to enter into treatment in the first place.

“They come into treatment at a older age as they have more to lose – wives, girlfriends, children”

“Guys that are older perhaps have gotten married, they might have children, they have managed to hold down a job and buy a house. So losing your house, losing your children, losing your wife, that is a pretty big incentive to actually kick yourself up the backside and force yourself to do something, whereas the youngsters may have lost a few friends and may be out of pocket but it fails to have an impact”

6.2.2.3.4 Bailout

Readiness to seek help was also affected by the fact that young people are often bailed out by family members or friends. This prolongs the point at which young people feel that they have no alternative options but to seek help.

“A lot of the time the parents are too soft and bail them out.”

“They are constantly being bailed out and they haven’t got a lot to lose, even though at times they might be homeless they haven’t got a lot to lose”

6.2.2.4 Environmental Barriers

It was perceived that barriers to accessing treatment may exist, which concern the wider environmental factors surrounding gambling and problem gambling treatment. A lack of awareness amongst friends, family and other professionals (e.g. teachers, GPs) may

contribute to the low rate of referral to appropriate sources of treatment for problem gambling. A lack of appropriate treatment services may also be an important factor.

6.2.2.4.1 Awareness

A general lack of awareness about problem gambling, and specifically treatment options, amongst all subgroups of society was suggested to play a role in the lack of treatment take up shown by young problem gamblers. Clinicians were asked how to combat the lack of treatment take up within this age group, and suggestions tended to focus on improving awareness within the general population about where to seek treatment for gambling problems.

“Spend more money on treatment and awareness of treatment, making sure people know where to go for help”

In order to target young people, schools were thought to be a useful way to get the message out, both via the education of young people and by educating people in positions of responsibility such as teachers and school counsellors.

“Have more literature. Schools do not get the message. My son is fifteen and when he was seven his schools were doing a raffle. He suggested that it was gambling, the schools don’t look at it in the same way.”

“I’ve always thought it would be good if somebody went round to colleges and schools to raise gambling awareness”

“Agencies aren’t geared, nor have the funding, to deal with it. They could go to school counsellors but if school counsellors aren’t educated [about problem gambling] they won’t know the questions to ask.”

6.2.2.4.2 Specifically tailored services

It was suggested that traditional forms of treatment for problem gambling may have intrinsic barriers to access for young people due to environmental factors, such as proximity of face-to-face counselling, or the structure of the existing treatment settings. For instance:

“There should be adolescent residential units, structured much differently, staffed 24/7, a lot more work around emotional and social development”

“Young people want instant gratification, they don’t want to travel as far as they have to travel”

It was suggested that online therapy could be a useful way of overcoming environmental barriers to treatment access:

“The majority of people who access online help are online gamblers. More women. They lose all their money then Google for help.”

“Young people generally look for online help. They don’t want to go to a GA group.”

6.2.3 Summary of Findings

This study highlighted a number of barriers to treatment access that clinicians think young people may face if suffering from problem gambling. Importantly, this data moves away from speculative accounts of barriers to treatment access towards empirical data. Although the data is not a direct first-hand account of the barriers to treatment access faced by young people, it is an important and useful account from a vital informant group who have experience of working clinically with this age group.

Many of the themes identified by clinicians in this study agree with what has been suggested in earlier literature. Poor verbal communication skills have been considered by a number of authors (Boughton & Brewster, 2002; Cooper, 2001, 2004; Hodgins & el-Guebaly, 2000; Rockloff & Sheffield, 2004) however this has only been discussed in the context of adults. The concept of emotional immaturity in young people, and in problem gamblers specifically, and its relationship with poor verbal communication skills is a one which has previously not been discussed in relation to this subgroup in the context of acting as a barrier to treatment seeking. However, evidence has shown that adolescents who gamble are less likely to have had a significant relationship and are more likely to have low self-esteem (Dickson, Derevensky, & Gupta, 2002; Fong, 2006; Gupta, & Derevensky, 2000).

Lack of awareness about gambling and problem gambling in this age group particularly has been identified (Gupta and Derevensky, 2000; Hardoon, Gupta and Derevensky, 2003) and may be due to a high level of social acceptability of gambling, combined with a lack of awareness of the possible harms associated with gambling.

The shame, secrecy, embarrassment, pride and fear of stigma associated with seeking help for gambling problems has been identified in both the general population (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002) and in young people (Chevalier & Griffiths, 2004; Griffiths, 2001). Further, the lack of life experience which may act as a barrier to help-seeking has been indicated with various authors talking about a need to hit rock bottom prior to seeking help (Abbott, 2001; Downs & Woolrich, 2009; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; McMillen et al, 2004) and this is something which is unlikely to occur in younger people due to bailout from parents or

friends, and the lack of significant amounts of money, possessions (e.g., a home) or relationships (e.g., spouse and children) they have to lose. Gupta and Derevensky (2000) suggest that adolescents may fail to recognize that they have a gambling addiction until their problems are relatively severe (e.g., legal actions pending against them, loss of friends, etc.) and report that by the time young people are willing to seek treatment for a gambling problem they are usually experiencing significant family, social, academic, and legal difficulties. This may also be linked to denial (ACNielsen, 2007; Chevalier & Griffiths, 2004; Evans & Delfabbro, 2005; Griffiths, 2001; Hodgins & el-Guebaly, 2000; Ladouceur et al., 2004; Nett & Schatzmann, 2005; Pulford et al, 2009) or an unwillingness to admit or a minimisation of the problems associated with gambling.

Problem gambling being a secondary issue to other things that require more urgent treatment is a concept which has also been previously visited in the literature (Chevalier & Griffiths, 2004; Griffiths, 2001) with suggestions being made that young problem gamblers may either not seek help because the problem is reduced in comparison to difficulties with other issues, or that they may already be seeking help for another issue, the treatment of which may also aid recovery from the gambling problem.

Specific factors about adolescence such as it being a time of engagement in a variety of risky behaviours, and that some young people 'grow out' of their gambling problem without outside help or may not experience long term problems with their gambling behaviour as interests change, have also been discussed in previous literature (Chevalier & Griffiths, 2004; Griffiths, 2001). The concept of peer influence has been explored in both the adult (Piquette-Tomei, Dwyer, Norman, McCaslin, & Burnet, 2007; Pulford et al, 2009) and adolescent (Chevalier & Griffiths, 2004; Griffiths, 2001) literature. This may take the form of pressure from others within their personal social networks to continue

gambling, or receiving a lack of support to make a change to their behaviour. Peer ambivalence is a nuance of peer influence which is of particular importance and has not previously been explored, suggesting that harmful gambling behaviour may be socially constructed to be non-problematic, and as such peers do not encourage help-seeking behaviour which may be an important motivator for young people in particular to seek help. The role of family and culture in help-seeking behaviour is particularly important for young people (Piquette-Tomei, Dwyer, Norman, McCaslin, & Burnet, 2007; Pulford et al, 2009). This warrants much further exploration given that although those young people from minority groups in Britain are less likely to gamble, when they do participate they are more likely to exhibit gambling problems (Ipsos MORI, 2009). Parental bailout was perceived to be a significant factor in the delaying of treatment seeking behaviour in young people, as has been suggested by Griffiths (2001; Chevalier & Griffiths, 2004).

In terms of treatment provision, findings from this study suggest that a lack of specifically tailored services for young people may be a barrier to help-seeking in young problem gamblers. This has been suggested in previous literature, with speculation being made that services may either not exist or not be suitable for young people (Chevalier & Griffiths, 2004; Griffiths 2001).

There are some interesting new findings that emerged from this study that have not been identified elsewhere in the previous literature. As highlighted above, the concept of emotional immaturity being a specific issue for young problem gamblers is a nuanced take on why this subgroup may struggle to communicate their problems and access treatment. The perception that young problem gamblers may have perceptions of treatment which are different from the reality of treatment provision is also an important finding, not only in uptake of treatment but also in relation to treatment drop out. This is linked to the general

lack of awareness that is perceived by clinicians to exist around treatment availability: this is a slightly different concept to awareness of gambling and what problem gambling is, rather it refers more to a lack of general social awareness that there are places to which young people can be referred if they are struggling with gambling problems.

Finally, this study highlighted some of the issues clinicians felt were central to their professional roles which may act as barriers to treatment access for young people. One perception was that clinicians may lack the appropriate skills required to work specifically with younger clients; a further perception was that there may be a lack of empowerment and flexibility available to individual clinicians within services to change the model under which they work to provide services to suit the needs of individual young problem gamblers.

6.3 Study 3b: Barriers to Treatment Access for Young Problem Gamblers: First Hand Perspectives.

6.3.1 Method

6.3.1.1 Participants

Initially, this study sought to recruit problem gamblers aged 16 to 20 who had not sought help for their gambling problem previously. Adverts were placed: in local shopping centres on both noticeboards and in both male and female public conveniences; on gambling discussion forums online (not problem gambling forums); and information was displayed in the lift and lobby areas of two higher education institutions in the UK. Adverts specified the types of respondents we were looking for (*Are you aged between 16 and 20 and have difficulty controlling your gambling?*), briefly explained the aims of the research, (*We are looking at ways to improve help, advice and treatment services for young people with gambling problems in Britain. To do this we need your help*), and a prompt to contact the researcher if they were interested, which on the physical adverts included tear-off slips with the researchers email address and mobile phone number. The online adverts specified that participants must be living in the UK. Although the posts on the gambling forums received a large number of views and the majority of the tear-off slips were taken, only three contacts were made, and none of these were willing to be interviewed when they found out more about the study.

In discussion with the supervisory team, the decision was taken to broaden the criteria for inclusion in the research to young problem gamblers who may have previously sought help, by including an advert on a problem gambling discussion forum based in the UK, and by asking the treatment providers who participated in study 3a whether they could refer anyone to take part in the research. Criteria were broadened further on the advice of

clinicians who had participated in study 3a, who suspected that finding participants under the age of 20 would be difficult: participants had to be under the age of 24 and had to have had a gambling problem which began when they were in their teens.

Six participants were recruited to take part in the study, all of whom were male and were aged between 17 and 22. All participants identified themselves as having a current gambling problem. Two were currently in treatment with a counselling service, and four had not sought formal treatment but had read information about problem gambling online. Five participants were regular users of the online problem gambling forum however only four were recruited directly from the online advert. Two were referred directly in to the research by the counselling teams. Further details about the participants can be found in Table 15.

Table 15: Demographic details and gambling history of participants

Participant	Age	Years of gambling	Type of gambling	Family/peer gambling?
1	17	2	Slot machines Scratchcards	Parents gamble
2	22	6	Slot machines Horseracing Internet poker	Parents, grandparent and peers gamble
3	21	10	Slot machines	Sibling gambles
4	18	2	Slot machines	Peer gambling
5	18	4	Slot machines Internet casino	No family or peer gambling
6	20	1	Internet poker Internet slot machines	Peer gambling

6.3.1.2 Materials

6.3.1.2.1 Interview Schedule

A flexible, open-ended interview schedule was devised comprising of a number of topics relevant to the aims of the research surrounding young problem gamblers views on barriers to treatment access. The main topics that were discussed are outlined in Figure 10. All interviews were recorded using a digital recording device and field notes were taken to aid later analysis.

Figure 10: Interview Schedule – Young Problem Gamblers

1. History of gambling
 - a. Age of first gambling
 - b. Types of games
 - c. Social/family network: gambling
2. Identification of problem
 - a. When
 - b. How did the problem manifest
 - c. How did you try to deal with it
 - d. Did you ever seek treatment
 - e. Experiences
3. Accessing treatment
 - a. Awareness of treatment type
 - b. Preferred treatment options
 - c. Problems perceived with accessing help
 - d. Reasons not to seek help
4. Ideal way forward
 - a. What would ideal service provision be?
 - i. Treatment?
 - ii. Awareness?
 - iii. Prevention?
5. Give information about appropriate help

6.3.1.3 Procedure

All participants were interviewed either face-to-face or via telephone. Face-to-face interviews were carried out in a private office which was rented in a building housing a number of generic business premises. Telephone interviews were carried out where participants lived some distance away. Participants were asked to read some information about the study that detailed what would be asked throughout the interview and how the

data were going to be used. Participants were assured that their responses would remain anonymous, but that their words may be reported verbatim in any written outputs in order to highlight the themes that came out of the analysis. All participants signed a consent form to show that they had understood the information and to consent to taking part in the research. Interviews ranged from 24 minutes to 72 minutes, and were recorded using a digital recorder. The interviews were then transcribed verbatim for use in data analysis.

6.3.1.4 Data analysis

As in study 3a, interviews were transcribed verbatim, and the resulting transcripts were analysed using a data-driven thematic analysis procedure outlined by Boyatzis (1998) and Braun and Clarke, (2001). For further description of this method see Chapter 3, Section 3.3.3.2. In Stage 1, responses to each question in a small selection of transcripts were read several times, and key words were noted as a means of reducing the raw data into categories. Themes were developed from the key words, to ensure saturation of data and identify themes that may be specific to individual questions. In Stage 2, data were examined for similarity of themes. Similar themes and their responses were grouped together in categories. At this stage, the interview transcripts were re-checked to ensure that responses had been ascribed to appropriate themes, and similar groups of themes were assigned broader category titles.

6.3.2 Results

During the course of the six interviews, participants described their experiences of problem gambling, their perceptions of treatment and whether they would seek help. They discussed concerns about seeking help and suggested ways in which they might be encouraged to ask for help. All participants felt that seeking help for problem gambling

was a difficult process, and suggested ways in which these difficulties might be overcome for others.

There were four main themes that emerged during the analytic process. Each category held a number of similar subthemes of ideas about barriers to problem gambling treatment access. The main themes were ‘Person-centred Barriers’; ‘Social Barriers’; ‘Treatment Barriers’; and ‘Knowledge and Awareness Barriers’ (see Figure 11). Each theme and its related subthemes are described in detail below.

Figure 11: Emergent Categories

<i>Emergent Categories</i>	
Person Centred Barriers	Fear, Intimidation and Judgement
	Stigma
	Need for privacy
	Do not want treatment
	Denial
Social Barriers	Importance of a crisis point
	Gambling not perceived as harmful
	Bailout
	Importance of family help
	Extrinsic motivation
Treatment Barriers	Importance of peer support
	Perception of group treatment
	Perception of online treatment
Knowledge and Awareness Barriers	Lack of understanding from counsellors
	Awareness of problem gambling symptoms
	Awareness of problem gambling help services
	Awareness amongst the general public

6.3.2.1 Person Centred Barriers

Participants were able to identify a range of feelings and thoughts about asking for help for their gambling problems, and a series of subthemes emerged under the theme ‘Person Centred Barriers’. This theme gets its title from the fact that these are participants’ intrinsic, personal thoughts and feelings that underlie the issue in consideration, rather than factors which exist outside of themselves.

6.3.2.1.1 Fear, intimidation and judgement.

Accessing treatment was perceived as a difficult process. Participants described feeling embarrassed about seeking treatment, and said they were put off because they would find it hard to verbalise their problem due to the embarrassment felt.

“I think it would be quite embarrassing and sort of hard to tell everyone about”

It appeared that physically going into a treatment service was something that young problem gamblers might find hard.

“The problem is having the guts to go in there to be honest”

“I think young people don’t have the confidence”

There was an unspoken perception by the majority of participants that treatment would be carried out in a group setting and this fear extended to feeling that other problem gamblers may be intimidating, or judge them because of their age.

“I feel intimidated by them”

“They might judge me cos I’m younger”

6.3.2.1.2 Stigma

There was a general perception that seeking treatment would be stigmatising, as people would find out which could affect the perception of them within their social group, damaging their self-image.

“I couldn’t tell my mates. They weren’t supportive. It was like a loss of self-pride”

This feeling of being stigmatised was exacerbated by feeling that no one else has a problem with gambling.

“I’m the only person who’s ever had a gambling problem that I know”

6.3.2.1.3 Need for privacy

There appeared to be a concern which was linked to avoiding stigma that seeking help may affect their privacy, which was perceived to be a very important aspect that was checked out during the help-seeking process.

“I’m very private about my life, I wouldn’t tell anyone my story“

There was a particular concern about online privacy when discussed in the context of being an avenue for seeking help and support.

“I go on the internet a lot for like Facebook, or music, but I wouldn’t put stuff about myself. I mostly text people online but I’m very personal what I tell people”.

Of particular concern, despite acknowledging its utility for some, was the possibility of their online account of a problem being traced back to them.

“Not online, I think it should be face to face. I don’t like going and posting stories. I think it’s silly posting things online. I don’t mind, it’s useful for people, but I would never post about me. It’s private, I wouldn’t tell my family, just my counsellor. It could be traced back. I would only tell people face to face”

6.3.2.1.4 Do not want treatment

In reflecting back to the time prior to actively seeking help for their gambling problem, the general feeling was that gambling was the most salient thing in their lives, and that they didn’t want to give it up.

“Gambling is more important. How can I win more money?”

Even during the course of treatment, some participants recalled deciding to stop and revert to their previous gambling behaviour.

“I just gave up; I just wanted to keep gambling”

Of particular note was a participant who admitted that, despite recognising his gambling problems, had not looked for help other than on online forums and hadn't stopped gambling because he enjoyed it too much.

“The trouble is there is always the chance of a relapse, I don't want to stop cos I kind of enjoy it”

6.3.2.1.5 Denial

There was a general perception that young people are not likely to accept that they have a gambling problem because they perceive themselves as too young to be in real difficulty.

“They think I'm only 18 I haven't got a problem, then they carry on till they are 24 and realise”

A gambler who had not sought treatment, despite losing £15,000 in the space of three days, minimised his problem and explained that he was too young and free of responsibility for it to be a real problem.

“I could be 24 and have a family and kids, I could be 30 having gambled £40,000. I'm lucky”

Often young people did not perceive themselves to fit in with their ideas of what a problem gambler is like, and used this as evidence to deny they had a real problem.

“A stereotypical person who gambles is not me. A stereotypical gambler is a thug, some dopey guy who smokes cannabis and has a crappy lifestyle. That’s what I think of a gambler”

Interestingly one gambler who played the lottery regularly denied that this contributed to a gambling problem, saying that:

“I wouldn’t class lottery as gambling cos I read a book about it. You have to be in control of the odds.”

6.3.2.1.5 Importance of a crisis point

Accounts were given of how a crisis point had to be reached before problem gamblers had been able to seek help. Usually this came when they had run out of money and could not hide the problem anymore.

“I didn’t want to tell anyone but eventually I had no choice”

“Then I got to the point where it was really bad and I had to get help”

The crisis point may trigger a range of lifestyle changes for young people will aid their recovery from problem gambling.

“I lost about £500 in one night, I didn’t pay my accommodation, I started lying to people. I live back at home now”

Without having reached a crisis point family members may not be aware that they need to take steps to intervene to help their loved one.

“I tried to commit suicide twice because of gambling. I tried to hang myself at uni. I tried to take an overdose and just felt like crap for two days. The only reason I’m here

right now is because of my brother. He put a tenner in my account and got me home and sat me down to self-exclude every single account”

6.3.2.2 Social Barriers

This theme explores the role of family and friends in initiating and supporting seeking gambling treatment, and also how social structure can inhibit or hinder treatment seeking efforts. Social perceptions of gambling as a fun activity rather than a problematic behaviour, and a lack of information about appropriate ways of helping problem gamblers, are key issues found throughout this theme.

6.3.2.2.1 Gambling not perceived as harmful

There was a perception that young people would not come forward for help for gambling problems because they compare their difficulties to those cause by other addictions, and feel that gambling is not a big problem.

“People think drugs is worse than gambling. I’ve realised it’s not”

6.3.2.2.2 Bailout

Parental bailout was identified as something which prolonged the problem gamblers experiences of difficulties. A pattern emerged whereby parents would find out about the problem gamblers difficulties and work to rectify their financial situation, often paying off debts and giving them extra money.

“They asked what state I was in with money and they helped but I still kept doing it”

Parental bail out tended not to solve the problem because it wasn’t accompanied by any extra support to stop gambling, and parents were often ill equipped to help.

“Mum never understood really, you can’t just go cold turkey in my opinion”

6.3.2.2.3 Importance of family help

Rather than contrasting with the last subtheme, the importance of family help emphasises that there is an important role played by a young person's family in enabling their help-seeking.

“I wouldn't have got any help without my family”

“My brother told me, he hassled me to go [to treatment]. He said ‘Do you want to have help’. I said yes, I was crying for help”

“Mum found betting slips in my pocket and they sat me down and said I had a problem”

For those who had not sought help it appeared that family played less of a supportive role in identifying problems and encouraging help-seeking; rather they were likely to be pertinent in the initiation of gambling behaviour, encourage continued gambling, and minimise perceptions of harm related to gambling.

“My cousin showed me the bookies round the corner. He gambles but not as much as us”

However in some cases, having other problem gamblers in the family allowed for the early recognition of a gambling problem.

“My granddad had a gambling problem so my mum knew what she was looking at.”

6.3.2.2.4 Extrinsic Motivation

Given the pivotal role family members play in encouraging and facilitating young problem gamblers to seek help, this was actually seen as a barrier to getting treatment, as although

they were going through the motions of attending treatment they did not want to be there and as such were not engaging in their own recovery.

“I went to treatment for my parents really”

“I went to [counselling centre], I went on the website, so it looked like I was sorting myself out, but I wasn’t, I did it for my parents.”

A typical perception was that young problem gamblers had to take responsibility for their own recovery before they could fully engage in treatment.

“They worry that [counselling centre] is not doing anything for me. I did it for two months and went back to gambling. I realised, why am I doing this? From that day I’ve never gambled since”

6.3.2.2.5 Importance of peer support

Having friends who gamble was a key inhibitor of treatment seeking. Peers would either minimise the issue or provide faulty social norms by which the young gambler would compare themselves and perceive that they did not have a problem.

“My mates took it as a laugh, no one offered any support”

“They just don’t realise how it can be a problem since they all gamble themselves”

Often a gambler would create a new social circle consisting entirely of gamblers which again facilitated the perception that their gambling behaviour was normal.

“I used to get along with people at the casino, they make you feel welcome. You feel like you are having fun. I used to have a laugh with the other people gambling”

Comparison of their behaviour with that of others their age that were also problem gamblers was important for all participants, and something which was difficult to achieve because most of them felt that there was no one else with a problem that they could talk to.

“I wonder what the worst is that, that’s why I want to speak to kids, people my age what’s the worst they have done?”

Key to help-seeking appears to be a drive to compare themselves with others with whom they identify.

“It’s nice to know how others have gone about it how they’ve stopped how well they are doing or not doing”

“What kind of situation they are in with their families and stuff, to realise how bad gambling is really, how bad a problem it is”

One way of accessing this type of information was online through problem gambling websites, which was seen to be more helpful than talking to parents and friends due to their lack of understanding of the problem.

“I go on there just to look, because, sort of with your parents and that it’s difficult, they don’t, it’s hard for them to understand”

“It’s nice to have other people in the same boat so that you can chat to them in a way”

When non-gambling peers tried to help it was not perceived as being helpful. These friends were reported as being easier to lie to in order to cover the behaviour.

“One of my housemates tried to stop me once but I just lied to them. I just lied to people about where I were. “I’m off to the shop”, I went to the bookies. I came back with nothing “I forgot my wallet”.”

It was difficult for peers to provide effective help and support.

“My girlfriend tried to help me through it and that didn’t work either...I dragged her into it to be honest”

6.3.2.3 Treatment Barriers

Young problem gamblers tended to hold faulty perceptions about how treatment was provided. The overwhelming perception was that they would only be able to access help through a group setting or online. There were concerns about the ability of counsellors who had not had problems with gambling themselves to help them, and concerns about the quality and effectiveness of treatment.

6.3.2.3.1 Perception that treatment is only provided in groups

Treatment was often perceived to be provided under the Gambler’s Anonymous model of group intervention. This was seen as a significant barrier to seeking treatment due to the reluctance to discuss their issues in front of a group.

“I would never stand up in a group of people like drug addicts do”

There were concerns that there would not be anyone in their age group at such treatment, and this acted as a barrier to seeking help.

“I would want a group, only young people not old people”

“When I go in the bookies there are older people in there, I reckon it [group treatment] would be like that”

There was a perception that older people would not be useful for them to talk to because they are not experiencing the same issues or living a comparable lifestyle.

“in [group treatment] the older people have been doing it for so long, the younger people I think it would be easier, you’d all be doing the same thing socially as well I would have thought, and that would affect it, I think it would help a lot”

The idea of a social support group, as opposed to a therapy group, was suggested by one participant, where young people could get together to discuss their problems with no pressure to talk in front of a large group. This links with the desire shown by young problem gamblers to compare their behaviour with their peers (see Section 6.3.2.2.5)

“The best thing would have to be an informal group to talk about issues. I enjoy hearing other people’s stories like me”

“I reckon groups for young people would be good. A drop in centre would be better”

6.3.2.3.2 Perception that treatment is online

In addition to the concerns about privacy outlined in the ‘Person Centred Barriers’ theme (see section 6.3.2.1.3) young people, somewhat surprisingly, did not think online treatment was a useful method of seeking help.

“Online it’s all a bit surreal, you can’t say what you feel or else you’d be there all day typing pages and pages and you can’t have a debate, get people to really think about what you are saying”

There was a general perception that although reading information from other people about their issues on line was useful, this was not an effective way of engaging in treatment.

6.3.2.3.3 Lack of understanding from counsellors

There was a perception that problem gambling treatment professionals were unlikely to have had a gambling problem themselves, and this was seen to be detrimental to their ability to help.

“It would be good to have a counsellor who has been through it, and recovered. Who can give you tips and say this is how I did it, and tell you what they’ve been through. It’s hard for people who haven’t been through it to understand”

One participant who had been to a single counselling session did not return for the further treatment offered because he found it hard to engage with the counsellor, due to the fact he couldn’t talk to them about his gambling experiences.

“He didn’t know what I was on about, I said about how I was playing this machine, what I was pressing and that, and he was blank, he had no idea. I was like, has he even ever seen a fruit machine?”

6.3.2.4 Knowledge and Awareness Barriers

6.3.2.4.1 Awareness of own problem gambling symptoms

There was a general perception amongst the young problem gamblers that the reason that they hadn’t sought help previously was that they didn’t realise they had a gambling problem.

“I should have realised it when I were younger”

“I just thought it was major fun till I was fifteen, sixteen, seventeen”

One participant described his surprise when he was initially searching for information about problem gambling online having suspected he might need some help.

“I did a quiz online and I ticked so many correct and thought wow, I’m actually a gambler, I’m really addicted”

6.3.2.4.2 Awareness of problem gambling help services

Young problem gamblers were generally unaware that there were any help services available for problem gambling.

“I’d have been doing it for a good two years I would have thought, I didn’t realise there was help out there as such”

The same is true for responsible gambling facilities provided by gambling operators, such as self-exclusion and signposting to help and support.

“I didn’t know self-exclusion was available”

“Signs in bookmakers are so small you never realise there is anywhere to go for help, its only once you realise you have a problem you start seeing them. It would be better to have them on the front of machines”

6.3.2.4.3 Awareness amongst the general public

There was a perception that if there was more awareness within the general public about gambling problems, how to avoid them and where to seek help that it would have been easier for them to seek help. Key areas that were suggested that awareness raising could be most effective were schools:

“No one ever ever talked about gambling. That would have been helpful. Gambling is the same addiction as drink and drugs. It should have been talked about in school.”

“I think people should be aware of gambling. I think the best way to stop someone gambling is having someone come to teach you that used to be a gambler. And knows, for example, I lived the shittiest life ever for a year, I felt like a dog. My room used to stink, I had a girlfriend who was amazing and I lost her. I used to be paranoid. Kids need to know”

“People should teach young kids about gambling. I don’t know who. They shouldn’t look at the benefits. I’ve got pictures of me when I was gambling and I looked like shit. That might work”

“Not just schools, but someone should just, I don’t know, they should make it more aware. I used to play a game at school and we put money on it and I didn’t think it was gambling. Maybe if I’d known I wouldn’t have done it”

It was also suggested that there should be more awareness raising efforts about problem gambling made for the general public.

“TV adverts would work for raising awareness”

“It should be like that Drinkaware, signs on all the bus stops and stuff. They did a good one with adverts about being sick on a night out and ruining everyone’s night. That kind of thing would be good. I could give some stories like that”.

6.3.3 Summary of Findings

All of the barriers to treatment seeking discovered through the interviews conducted in this study have been previously identified in the research literature, however this is the first investigation which has been able to ground them in empirical data which has come first hand from young problem gamblers themselves.

Feelings of fear, intimidation or judgement have been previously identified by a number of authors as a barrier to seeking treatment for problem gamblers, as has the perception of potential stigma related to help-seeking behaviour and the desire for privacy or secrecy (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002;). Not wanting to stop gambling or seek treatment has been discussed with reference to the general population (Boughton & Brewster, 2002; Tavares et al, 2002; Evans & Delfabbro, 2005) and specifically with regards to young people (Chevalier & Griffiths, 2004; Griffiths, 2001). Denial has also been addressed in the literature with reference to adults (ACNielsen, 2007; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Nett & Schatzmann, 2005; Pulford et al, 2009) and adolescents (Chevalier & Griffiths, 2004; Griffiths, 2001; Ladouceur et al., 2004). The importance of reaching a 'crisis point' in order to seek problem gambling treatment has been well documented (Abbott, 2001; Downs & Woolrich, 2009; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; McMillen et al, 2004). Reaching 'rock bottom' is an important factor in seeking help, and has been suggested as something that not often occurs in young people due to parental bailout, and to link to the lack of significant amounts of money, possessions (e.g., a home) or relationships (e.g., spouse and children) to lose. However findings from this study would challenge this assumption, as crisis points do not have to be financial for young people; where they are, even though they may not involve losing a house, the loss of a month's rent money, or even a month's pocket money, can constitute a financial crisis. Participants in this research also described crisis points as including suicide attempts and relationship breakdowns.

Not perceiving gambling as something which can be harmful is an important barrier to help-seeking for young people. In particular young people may not be aware of the harms associated with their behaviour (Gupta and Derevensky, 2000; Hardoon, Gupta and

Derevensky, 2003) or this issue may be socially constructed as non-problematic or minimised by their social groups (Chevalier & Griffiths, 2004; Griffiths, 2001; Piquette-Tomei, Dwyer, Norman, McCaslin, & Burnet 2007; Pulford et al, 2009).

Bailout was found to be an important barrier to help-seeking for young problem gamblers, often delaying treatment seeking. This confirms speculation (Chevalier & Griffiths, 2004; Griffiths, 2001) that bailout may be a barrier to treatment seeking. While family are seen as vital to initiating help-seeking for young people, they may also try to contain the problem via bailout and providing their own support, putting in boundaries for example, and this may be ineffective and delay or inhibit formal treatment seeking. Where young people are encouraged or forced to seek help, the fact that the motivation for this is extrinsic often means that they either do not engage fully with treatment or drop out.

There was a strong perception that treatment for young problem gamblers was only available in group settings or online. Treatment misperceptions and concerns have been highlighted in previous literature (Hodgins & el-Guebaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004) but this has not been identified previously as a specific concern for young people. Concern about what happens in treatment and whether treatment providers would be experienced in gambling enough to discuss those issues which young people felt were relevant were identified as barriers to treatment seeking. Again these are issues which have been previously speculated upon by Griffiths (2001) and Chevalier & Griffiths (2004).

Awareness about problem gambling, its symptoms, and available help services were identified as major barriers to adolescents seeking help. Participants suggested that the importance of the issue should be highlighted in schools, reporting that the lack of information they received at school may have played a role in the development and

maintenance of their problem. The lack of awareness within the general population was also highlighted. It may be that problems would be identified sooner and help-seeking encouraged if more people were able to spot indicators of youth gambling problems.

6.4 Comparison of Emergent Categories from Study 3a and Study 3b

As shown in Figure 12 the emergent categories from studies 3a and 3b can map onto each other with some important similarities and differences between categories. The category entitled ‘Clinician-centred Barriers’ which emerged from the interviews with problem gambling treatment providers has much in common with the ‘Treatment Barriers’ category identified from the analysis of interviews with young problem gamblers. When considered together this may most helpfully be titled ‘Treatment Barriers’. The subtheme ‘lack of skills’ from study 3a may have much in common with the perception from young people in study 3b that there may be a ‘lack of understanding from counsellors’ about the issues they face. However this category also holds some interesting differences. The clinician’s experience of a ‘lack of empowerment’ was unsurprisingly not something identified by young problem gamblers. Conversely, treatment providers did not consider the perceptions of young people about the unsuitability of treatment being offered online or in groups as a barrier to accessing treatment. This is an important finding for services considering setting up a treatment programme for young people.

Figure 12: Similarities and Differences between Emergent Categories from Study 3a and Study 3b

	<i>Study 3a – Emergent Categories, Treatment Providers Interviews</i>		<i>Study 3b – Emergent Categories, Young Problem Gamblers Interviews</i>	
TREATMENT BARRIERS	Clinician – Centred barriers	<ul style="list-style-type: none"> • Lack of skills • Lack of empowerment 	Treatment barriers	<ul style="list-style-type: none"> • Perception of group treatment • Perception of online treatment • Lack of understanding from counsellors
ENVIRONMENTAL BARRIERS	Environmental barriers	<ul style="list-style-type: none"> • Societal awareness • Specifically tailored services 	Knowledge and awareness barriers	<ul style="list-style-type: none"> • Awareness of problem gambling symptoms • Awareness of problem gambling help services • Awareness among the general public
SOCIAL AND MOTIVATIONAL BARRIERS	Motivational barriers	<ul style="list-style-type: none"> • Point of referral • Peer ambivalence and peer pressure • Role of family and culture • Bailout 	Social barriers	<ul style="list-style-type: none"> • Gambling not perceived as harmful • Bailout • Importance of family help • Extrinsic motivation • Importance of peer support
GAMBLER-CENTRIC BARRIERS	Client-centred barriers	<ul style="list-style-type: none"> • Emotional immaturity and poor verbal communication skills • Lack of awareness about problem gambling • Stigma about help-seeking and mental health issues • Denial • Unrealistic treatment expectation and drop out • Adolescence as a time of excess • Gambling as a secondary issue • Lack of life experience 	Person-centred barriers	<ul style="list-style-type: none"> • Fear, intimidation and judgement • Stigma • Need for privacy • Do not want treatment • Denial • Importance of a crisis point

The category 'Environmental Barriers' which emerged from Study 3a has some overlap with the category 'Knowledge and Awareness Barriers' which emerged from Study 3b; combined, these might be most helpfully labelled 'Environmental Barriers'. Both treatment providers and young problem gamblers identified a lack of awareness about problem gambling in society as a barrier to seeking treatment for young people; however the young problem gamblers broke this down more specifically into a lack of awareness about problem gambling symptoms, about help services available for problem gamblers and a lack of awareness amongst the general public that gambling can cause harm. Treatment providers suggested that a lack of specifically tailored treatment services available to young people was a barrier to treatment access.

The category 'Motivational Barriers' which emerged from Study 3a has much in common with the category 'Social Barriers' which emerged from Study 3b. Both treatment providers and young problem gamblers identified that bailout plays a role as a barrier to treatment access. The roles of family, culture and peer support in encouraging or discouraging help seeking was also identified by each group, with issues around whether others perceive gambling as harmful or not, and whether young people were intrinsically or extrinsically motivated to seek help both being cited by both groups as important constructs. Young people suggested that gambling was often not perceived as something which could be harmful, acting as a further barrier to seeking help.

Studies 3a and 3b both identified barriers to treatment access for young problem gamblers which might helpfully be categorised as 'Gambler-centric barriers'. In study 3a these were called 'Client-centred Barriers' reflecting the role that a young problem gambler plays in the treatment providers context. In Study 3b, they were called 'Person-centred Barriers'. Both groups identified the subthemes 'Denial' and 'Stigma' as barriers to treatment access

for young people. The finding from Study 3a that young problem gamblers do in fact reach crisis points which, although perhaps qualitatively different than an adult crisis point, still has an impact on treatment seeking behaviour.

6.5 Discussion

Findings from the studies presented in this chapter provide a vital piece in the jigsaw of information exploring why young people tend not to seek help for gambling problems. The studies not only grounded ideas from what may have previously been speculative accounts of help-seeking in young people, or empirical accounts from older groups, in empirical data from young people themselves, but also generated more nuanced understandings of the themes discussed in previous literature and identified issues which may not have been previously discussed.

An important new finding was the concept of emotional immaturity being a particular barrier to successful treatment access for young problem gamblers. Successful treatment must not only address the gambling behaviour, but also help the young problem gambler navigate the normal developmental tasks of identity formation that are often neglected while using gambling as a means of coping with life's problems. For instance, evidence has shown that adolescents who gamble are less likely to have a significant relationship and are more likely to have low self-esteem (Dickson, Derevensky, & Gupta, 2002; Fong, 2006; Gupta, & Derevensky, 2000). Part of effective therapy for this age group may be coaching in life skills. Treatment might usefully focus on effective problem-solving and social skills necessary to build self-esteem, verbal ability, and emotional awareness. Non-verbal methods of treatment should be examined for use with young problem gamblers, perhaps borrowing from the skills used by those providing Child and Adolescent Mental Health Services (e.g., Riley, 2001).

As part of intervening with a young gambler, communication skills may also need to be taught. As highlighted in this study, young gamblers may have a lack of communication skills in face-to-face situations, and this could lead to poor self-esteem, feelings of isolation, and create additional problems in life. Part of the therapeutic process needs to help young people to communicate with others. This research highlights the discrepancy between treatment offered and what, anecdotally, comes to mind when thinking of problem gambling treatment – group work with a focus on talking rather than doing problem solving tasks. It also highlights that clinicians have differing views about the type of work that suits young people best. It may be that further training is needed for clinicians working with problem gamblers to learn techniques and skills for treating young people, as it seems effective methods are different than effective methods with older problem gamblers.

A novel finding was the concerns from clinicians themselves around their ability to provide a specific service for young people, either through lack of skill or being unable to have flexibility in their approach. Related to this was the concern from young people about clinicians' understanding of gambling and gambling problems. Treatment providers may need to provide more information about personal experience of gambling, or work to make young people feel confident in their awareness of the issues being discussed, if treatment is to be sought and carried through.

Clarity regarding the fact that young people can and do reach 'crisis points' at which the desire to seek treatment is triggered was gained from the study exploring barriers to treatment access with young problem gamblers. The relevant issue is that the crisis point may be qualitatively different to that experienced by an older problem gambler, but none the less salient. While young problem gamblers may not have mortgages to lose, losing a

relatively small amount of money may result in significant issues triggering important life changes e.g. as in the case of one study participant, losing £200 could mean not paying a month's rent at university and having to move home, being unable to continue studies and having to admit the problem to a variety of people including family and friends.

An important finding from the study which explored barriers to seeking treatment with young problem gamblers themselves was that the previously identified barriers suggesting that problem gambling could be a secondary issue to other problems being experienced by young people, and that young people engage in a variety of risky behaviours during adolescence, appear to be refuted by this study. All participants described gambling as the only salient problem in their lives, suggesting that although they may drink, take drugs, be bullied, have academic problems or problems at home, none of these are primary issues. This seems to be at odds with speculation that problem gamblers may not seek treatment for gambling problems because they are seeking help for other issues instead. Rather this research would suggest that although they may partake in other risky behaviours and experience negative affect due to other problems, none of them are considered problematic in comparison to the gambling behaviour. However it should be noted that this sample were all self-identified problem gamblers who had either sought help formally or had searched for information about problem gambling online. This may mean they have different experiences of problem gambling than those who did not view it as a primary problem and were seeking help for other things.

Denial of the problem, although not a newly identified barrier to treatment seeking in young people, was a particularly interesting subtheme as the participants in this study were all self-identified problem gamblers, however some still discussed gambling problems as though they didn't particularly affect them. This construct requires further exploration.

It is also important to consider a young person's individual situation when treating their gambling problem. It is necessary to look at family dynamics, such as family history of addiction, background, and/or conflict, and how these factors may be impacting a young person's developmental stages, emotional well-being, and self-esteem (Yen et al., 2007). There is both the problem of young people being introduced to gambling by their parents, and the problem of those who get into difficulties being bailed out. While this may seem like a helpful strategy in the short term, in the long term it has only been shown to prolong the gambling problem and the crisis point at which the gambler seeks help. Parents and other caregivers need to be educated about the potential dangers of excessive gambling and given advice about how to cope with a problem in the best long-term interests of the young person.

6.5.1 Limitations

These studies are limited in that they only obtained data from a small sample of individuals. However, there are only a small number of clinicians currently working in the problem gambling field in the UK who have experience of working with young people around these issues. The breadth of expertise and variety of clinical settings from which those who took part in this study were drawn does go some way towards making up for the small sample size; the study included almost all of the best known problem gambling treatment professionals in the UK. The number of problem gamblers accessed was particularly small, and there were methodological issues which meant that the ideal representative sample of non-treatment seeking problem gamblers was not obtained. However, the difficulties with recruiting problem gamblers to research have been well documented (Parke & Griffiths, 2002), a problem exacerbated by the target sample being young.

It may be that given the political climate surrounding gambling in the UK, it could be argued that each of the clinicians surveyed may have given answers that were geared towards their own services agenda. At the time of the research, funding for treatment services for problem gamblers was being discussed and reviewed by the Responsible Gambling Strategy Board, with a new system of funding due to be put into place by in the following two years. The implications of research outputs being produced by academics in the field advocating a particular method of service delivery may have important political and financial implications for the individual clinicians and their institutions.

The clinicians interviewed in the first study may also have had very little idea about what the actual and experienced barriers to treatment access are for young problem gamblers; intuitively clinicians only tend to see those young problem gamblers who have sought treatment for their problem. The second study went some way towards combatting the issue of participant knowledge, however was limited by asking for retrospective accounts of why they didn't seek treatment. This emphasises the necessity for research which asks non treatment seeking problem gamblers themselves why they do not access treatment.

The data from young problem gamblers was retrospective and self-report, which may mean that the reported experience of not seeking help was somewhat distorted, given that all participants subsequently had sought help. A function of the recruitment strategy used to obtain the participant sample was that those who have not yet acknowledged or realised that they have a gambling problem were not included, and this is likely to be a major barrier to help-seeking behaviour. Without population based surveys however this is likely to be a difficult limitation to overcome.

6.5.2 Further Work

Further research could usefully explore issues concerning appropriate treatment for young problem gamblers from a range of mental health professionals in order to understand what might be most applicable and accessible for this age group. It is also important to look at what education and prevention strategies work in getting young people to understand the potential dangers associated with excessive gambling, the signs of a developing gambling problem, and how to access appropriate help, advice and support. There needs to be further research into efficacy of treatment, the efficacy of awareness raising, and education programmes, both within school settings but also amongst families and the wider community.

6.5.3 Conclusion

Whilst these studies usefully explored the understanding of what barriers there may be to young people accessing treatment for gambling problems, and generated new findings around how these barriers may be experienced, they do not give us an understanding of which issues are most salient to young problem gamblers themselves. This is vital for any application of these findings in the real world context and will be addressed in the final study of this thesis, presented in Chapter 7.

Chapter Seven: Subjective Experiences of Barriers to Treatment Access for Young Problem Gamblers

The qualitative studies described in chapter six have for the first time empirically explored barriers to treatment access for young problem gamblers, which has elucidated and explained some of the key barriers. However, what is lacking is an understanding of the salience of these barriers. What factors are more important than others, and for whom? Given the theoretical and actual difficulty with recruiting young problem gamblers to participate in research (see section 6.3.3.1) illuminating this area lends itself very well to Q methodology, which requires a relatively small sample size to explore subjectivity of opinion (van Exel & de Graaf, 2005). This chapter will describe a Q methodology investigation of barriers to treatment access for young people.

7.1 Introduction

It has been consistently shown that young people exhibit high rates of problem gambling, with in Great Britain having a problem gambling prevalence rate of 2% amongst 12 to 15 year olds. This equates to around 60,000 young people in the UK (GamCare, 2010) and is twice as high as the prevalence rate found in adults (Wardle et al, 2011). It has been suggested by a wide array of authors that there may be particular barriers to treatment access for both young people and problem gamblers (see chapter 2 for a detailed overview of the literature on help-seeking behaviour, and Section 6.1.2 for a summary of the psychological literature covering barriers to treatment access specific to problem gamblers). Analysis of data undertaken as part of the programme of research presented in this thesis suggests that young people are generally not aware of many of the distinctive signs and symptoms exhibited by problem gamblers, and that they do not know where or how to seek sources of help for problem gambling (see Section 5.3).

Much of the literature which has discussed barriers to help-seeking in young problem gamblers has been speculative (Chevalier & Griffiths, 2004; Griffiths, 2001), or has not explored empirically the issues in a group of young problem gamblers. The only empirical study found which looked at barriers to help-seeking in young problem gamblers (Ladouceur et al, 2004) sampled young people based on whether they knew a problem gambler, rather than if they were one themselves. Therefore there was a significant gap in the research on this topic which has been, to some extent, addressed in the studies presented in Chapter 6. However, study 3b, which explored qualitatively the experiences of young problem gamblers in relation to help-seeking, was limited in that there were difficulties in recruiting young problem gamblers who had not yet sought any form of treatment to the research. When recruitment criteria were expanded to include those who may have explored avenues of help-seeking (e.g. by including adverts for participants on forums aimed at problem gamblers) it was still only possible to recruit six participants to the research. This may be due to a number of issues that are related to the sample being both young (Munford & Sanders, 2004), and being problem gamblers.

Fargas-Malet, McSherry and Larkin (2010) consider the particular difficulties in engaging young people in research may be overcome by using participatory research techniques. Participatory research enables participants to create 'inclusive accounts using their own words and frameworks of understanding' (Pain & Francis, 2003). Grouping and ranking exercises have been found to be particularly useful with young people (Punch, 2002; Thomas & O'Kane, 1998). The particular strengths of using Q-methodology studies with young people are that they can be carried out using semantics that are familiar and accessible, and that they are adaptable to different delivery modes, for example using computer/web based software (Burt et al, 2007; Hackert, 2007) which is particularly useful for accessing those who may be more reluctant to seek help or engage in research.

Q methodology was developed to explore the subjectivity of opinion (Stephenson, 1935) within a population, and necessarily therefore requires fewer participants. Q methodology aims to explore meaning in a body of information, rather than across a large sample. Q methodology has been applied to a number of psychological research areas including social psychology (Curt, 1994; Stenner & Eccleston, 1994); child abuse (Stainton Rogers & Stainton Rogers, 1992); jealousy (Stenner & Stainton Rogers, 1998); love (Stenner & Watts, 1998) and attitudes to environmental issues (Capdevila & Stainton Rogers, 2000). However, despite being ideally suited to researching constructs within a young problem gambler population, this method has not yet been employed in this context. Conversely, empirical evidence has not been sought to explore the salience of the barriers to treatment access identified in previous literature amongst young problem gamblers.

This study aims to use Q-methodology to explore opinions about barriers to treatment seeking in young people with gambling problems.

7.2 Method

The stages involved in designing and conducting Q methodological research are described in detail in section 3.3.4. In summary, researchers employing Q methodology must develop a concourse of information, from which they must define a set of statements about the topic under consideration, named the Q-set. Participants (the P-set) must be recruited to the research and instructed in carrying out the Q-sort task. The Q-sorts arising from the research are subjected to factor analysis in order to draw out meaningful clusters of opinion, which are then interpreted by the researcher according to the topic at hand. This section will describe the stages of Q methodological research as employed by this study.

7.2.1 Development of the Concourse and Resulting Q-set

The concourse can be thought of as “the breadth of debate or thought around a particular issue” (Jeffares & Skelcher, 2010, p.11). For this research the concourse consisted of the actual or perceived barriers that might exist for young problem gamblers with regards to seeking help for their gambling problem. This concourse was captured from a range of sources including academic literature on both general barriers to help-seeking, and barriers for problem gamblers in particular; from inferences made from the data explored in studies 1 and 2 presented in Chapters 4 and 5 of this thesis; and from the accounts given by both problem gambling treatment providers and problem gamblers themselves during the course of studies 3a and 3b presented in Chapter 6 of this thesis.

The concourse was represented in a series of 96 short statements. Each of these statements was piloted with a small sample of adolescents (two girls, aged 13 and 16, and a boy aged 14) to ensure that they could easily read and understand the meaning of each of these statements and to eliminate ambiguity in wording. Ambiguous statements were redrafted, and where possible those statements which related to the first-hand accounts given in studies 3a and 3b captured the language or the way the issue was articulated by participants.

Concepts or themes which were duplicated were eliminated, and the concourse was subsequently narrowed down into 49 statements which were representative of opinion on the topic and made up the Q-set. See Appendix 2 for a summary of each statement in the Q-set and justification of its inclusion based on published literature and findings from the current program of research.

7.2.2 Participants (P-set)

Given the difficulties encountered with recruiting young problem gambling participants to the research encountered in study 3b, the initial recruitment strategy employed all the methods outlined for recruitment of participants in that study: adverts were placed in local shopping centres on both noticeboards and in both male and female public conveniences; on gambling discussion forums online and problem gambling forums; and information was displayed in the lift and lobby areas of two higher education institutions in the UK. Physical adverts included tear-off slips with the website address at which the research task could be found. All those young problem gamblers who had participated in study 3b (n=6) were asked to take part in the task; however it was not possible to track whether any followed this up.

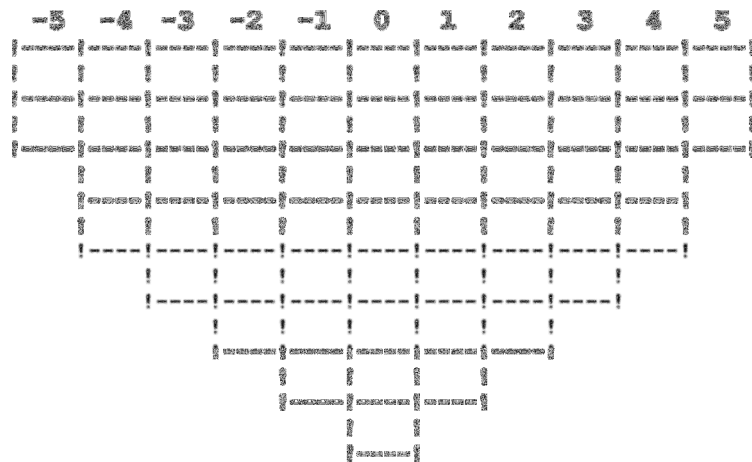
No lower age limit was placed on participation in this research; however no one under the age of 16 took part. A total of 21 participants were recruited to the research, the vast majority of whom (n=18) were male. Ages ranged from 16 to 21, and the mean age was 17.95 years. All participants said they believed themselves to be a problem gambler.

7.2.3 The Q-sort Task

Ways in which the research could minimise any potential barriers to this group taking part in it were sought, and as such the research was conducted online, given the potential issues with accessibility and time. Q methodology research lends itself well to online applications (Hackert, 2007) and as such the FlashQ software programme (Braehler & Hackert, 2007) was utilised to create an online sorting tool which was then placed on its own web domain for specific use with this research. The sorting task operates in much the same way as the PC game Solitaire with participants using the mouse to drag and drop statement 'cards' into relevant areas on-screen.

Participants were asked to sort the statements in order of agreement on to a Q-sort grid ranging from -6 (disagree) to +6 (agree) (See Figure 13). They did this by first sorting them into 3 piles: agree, neutral and disagree. They were then asked to place them in the grid relative to each other in terms of agreement or disagreement in relation to whether they were perceived as a barrier to the participant seeking help.

Figure 13: Example of a Q-sort grid



7.2.4 Analysis

The responses were analysed using PQ Method, a DOS-based statistical program designed specifically to carry out the necessary statistical functions of Q analysis. Firstly the data from each Q-sort was entered into the program. The data was then subjected to series of analyses: Horst's (1995) centroid factor analysis; varimax factor rotation; and the extraction of factors for analysis. Watts and Stenner (2005) provide a useful discussion of the options a Q methodologist may take in conducting the analyses given the choices available to conduct both factor analysis, rotation and extraction. In this case, centroid factor analysis was chosen over principle component analysis as despite not resulting in a mathematically superior solution, it allows for a more flexible approach to the analysis and a theoretically more informative solution to be reached. This was followed by a varimax rotation, which was employed as at this stage to ensure the mathematically superior

solution was reached, which was consonant with the aim of explaining the most amount of variance within the sample and as such allowing the exploration of the range of viewpoints within the group.

The resulting factor arrays were subjected to interpretation and a series of summary accounts were developed for each factor. These will be presented in section 7.3.

7.3 Results

Subsequent to centroid factor analysis, participants with a loading of 0.37 and above were automatically flagged for a varimax rotation. The factor analysis was run several times rotating between 2 and 7 factors. In each case, explained variance was checked along with eigenvalue, the number of significant persons loading, the numbers of persons not loading on any factor, the number of persons confounded across more than one factor, and the correlation between factors. A four factor solution was found to be superior, and all four factors met the standard conditions, namely that they had eigenvalues greater than one, and had two or more people loading significantly on each factor (Watts & Stenner, 2005). See Table 16 for factor loadings. The four factors together explained 29% of the variance across the set. Although the total of 29% is less than that hoped for in ordinary factor analysis, in Q-methodology the main objective is finding the salient viewpoints, not identifying the number of factors that can explain a large percentage of the total variation.

Table 16: Factor loadings

Sort	Age	Gender	Factor A	Factor B	Factor C	Factor D
1	16	Male	0.5711*	-0.1234	0.3006	0.2705
2	20	Male	0.6519*	0.0262	-0.1577	0.0581
3	16	Male	-0.2216	0.2063	0.3672*	0.1978
4	19	Female	0.2323	-0.5879*	0.1512	0.0080
5	17	Male	0.1289	0.2616	0.0710	0.6422*
6	19	Male	0.4992*	0.0808	-0.1924	0.0443
7	21	Male	-0.2971	0.5914*	0.1556	0.1013
8	19	Female	0.0728	0.1632	0.0049	0.4262*
9	18	Male	0.0030	0.2111	0.3408*	0.0095
10	16	Male	-0.2424	0.0360	-0.0069	0.1001
11	17	Female	0.5143*	-0.1341	-0.1415	-0.2990
12	17	Male	-0.0521	0.1032	-0.5807*	0.0352
13	17	Male	0.2089	0.0478	-0.4286*	-0.0276
14	18	Male	-0.0457	-0.5529*	0.0505	-0.1826
15	18	Male	0.1611	0.0307	0.2701	-0.4322*
16	17	Male	0.1885	0.3729*	-0.0284	0.1740
17	19	Male	-0.0233	-0.2109	0.4457*	-0.1539
18	18	Male	0.0255	0.1820	0.0857	-0.1046
19	19	Male	0.2177	0.2383	0.1023	-0.4652*
20	18	Male	0.0544	0.1431	0.2703	-0.0958
21	17	Male	0.4343*	0.0292	0.2470	0.0303
% explained variance			9	7	7	6

*indicates a defining sort

The most informative data is contained in Table 17, which shows the item scores for each factor.

Table 17: Factor Array	Statements	Factor Arrays			
		A	B	C	D
01	All my friends gamble so if I stopped I would have no one to socialise with	-1	1	6	4
02	My family gambles a lot so I don't think I have a problem	-6	-1	0	6
03	I don't want to give up the financial rewards of gambling	4	2	5	1
04	I need to keep gambling to win back my losses	0	1	-3	1
05	I don't want to get any help	-3	2	3	0
06	There are no treatment services available for me	0	2	-4	-1
07	I can't get to treatment for problem gambling	3	3	-1	-2
08	Treatment would be too expensive for me	5	-2	2	0
09	Problem gambling treatment is not designed for young people	3	1	1	0
10	I wouldn't fit in at problem gambling treatment	2	0	5	-1
11	I would prefer to talk to someone who has had a gambling problem	6	-2	2	-5
12	I would prefer to speak to someone who could help me with all my problems	4	4	-3	2
13	I would prefer to talk to a problem gambling specialist	-2	-6	0	-1
14	I would prefer to get help online	5	-3	-5	-2
15	I would prefer to go to get treatment in a group with other people my age	3	-5	-1	5
16	I would prefer to get treatment by speaking to a therapist face to face	0	-4	4	-1
17	I don't need treatment because my parents and friends will bail me out	-4	-5	4	-2
18	All my friends gamble as much as me and we don't need help	-5	-1	3	-4
19	I don't want to stop gambling	-1	0	4	-2
20	I enjoy gambling so I don't want to seek help	-3	0	3	-3
21	Problem gambling isn't very serious	-4	4	2	1
22	I told someone about my problem gambling but they didn't think it was an issue	-1	5	1	2
23	I don't need help with my gambling	-1	0	1	0
24	I have too many other problems to worry about gambling	-2	4	1	1
25	I don't seek help for problem gambling because I am getting help for another problem	1	-2	-3	5
26	I would be able to tell a friend if I had a gambling problem	1	-4	2	3
27	I can get help to stop gambling from my family so I don't need to seek treatment	1	-4	-1	0

28 I gamble a lot by choice, not because I am addicted	-4	3	-2	2
29 I gamble more than I want to but my problem really isn't that bad	-5	2	-6	2
30 Other people want me to get treatment but I don't think I need it	0	6	-4	1
31 I don't need treatment	-1	0	0	2
32 I wouldn't seek any treatment for a problem that isn't physical	-3	-2	-1	-5
33 I have my problems under control by myself	1	3	0	-2
34 I don't have time to go for treatment	2	1	1	-2
35 I am too ashamed to admit I have a gambling problem	-2	-2	-2	-4
36 I am worried what other people will think of me if I seek help	4	-3	-1	-6
37 I would never admit to having a gambling problem	-2	3	0	-4
38 I wouldn't trust a counsellor not to tell my family	1	1	2	-1
39 People will find out if I start getting treatment	3	1	0	3
40 I don't like talking about my problems	-3	5	3	0
41 I struggle to tell people how I feel	2	-1	0	4
42 Treatment wouldn't work for me	-1	0	-2	1
43 Treatment doesn't work for anyone	1	-3	-2	-3
44 I'm too young to have a real gambling problem	0	2	-1	4
45 I don't seek help because there is no service available in my area	0	-1	-4	-1
46 I am too proud to admit I have a problem	-2	-1	-2	-3
47 I don't know what happens in treatment	2	0	-5	3
48 I don't know where to seek treatment	0	-1	-3	0
49 I don't know who to tell about my gambling problem	2	-3	1	3

The four factors (A-D) accounted for 18 of the original 21 sorts and are described in more detail below. All statements are followed by a statement number and sort position. Singular positive and negative numbers relate to the sorting position of an already highlighted statement.

7.3.1 Factor A: Stigma and Self-Awareness

Problem gamblers loading upon Factor A (n=5) were four males and one female who had a mean age of 17.8 years. Factor A explained 9% of the study variance and had an eigenvalue of 1.46.

7.3.1.1 Factor interpretation

These problem gamblers feel very strongly that they would prefer to talk to someone who has had a gambling problem (11; +6), but thought that treatment would be too expensive for them (8; +5). They were worried about what other people would think of them if they sought help (36; +4) wanted to speak to someone who could help them with a range of problems (12; +4) and were keen to get help online (14, +5). They were aware of the severity of their gambling problems, typified by the strong disagreement with statement 29 “I gamble more than I want to but my problem really isn’t that bad” (-5) and that Factor A is alone in disagreeing with statement 21 “Problem gambling isn’t very serious” (-4). They showed evidence that they gambled more than both family and friends, strongly disagreeing that their families gambled a lot (2; -6) or that their friends gambled as much as them so they didn’t need help (18; -5). Factor A is alone in agreeing that treatment doesn’t work for anyone (43; +1), however showed more willingness to seek help, typified by disagreeing with statement 40 “I don’t like talking about my problems” (-3) and 5 “I don’t want to get any help” (-3).

7.3.2 Factor B: Denial and Treatment Resistance

Problem gamblers loading upon Factor B (n=4) are three males and one female who had a mean age of 18.75 years. Factor B explains 7% of the study variance and has an eigenvalue of 2.05.

7.3.2.1 Factor interpretation

Problem gamblers loading significantly upon Factor B are characterised by denial and resistance to treatment. They strongly agreed with statement 30 “Other people told me to get help but I don’t think I need it” (+6) and statement 22 “I told someone about my gambling problem but they didn’t think it was an issue (+5). They said that they would never admit to having a gambling problem (37; +3) and said they had their problems under control by themselves (33; +1). They strongly disagreed with preferring to speak to a problem gambling specialist (13; -6) and strongly disagreed with being likely to receive parental bailout (17; -5). They also expressed strong disagreement with wanting to seek help in a group (15; -5); from family (27; -4); face to face with a therapist (16; -4); and being able to tell a friend (26; -4). Factor B was alone in disagreeing with statement 8 “Treatment would be too expensive for me” (-2).

7.3.3 Factor C: Peer Pressure, Bailout and Reluctance to Stop Gambling

Problem gamblers loading upon Factor C (n=5) are all males, who had a mean age of 17.4 years. Factor C explains 7% of the study variance and has an eigenvalue of 1.56.

7.3.3.1 Factor Interpretation

Problem gamblers loading significantly on Factor C are characterised by being affected by peer pressure. They strongly agreed with statement 1 “All my friends gamble so if I stopped I would have no one to socialise with” (+6). This was also the only factor to agree with statement 18 “All my friends gamble as much as me and we don’t need help (+3);

and statement 3 “I enjoy gambling so I don’t want to seek help” (3). They also strongly agreed with statement 10 “I wouldn’t fit in at problem gambling treatment” (+5). They have a good level of awareness of treatment available to them, strongly disagreeing with statement 47 “I don’t know what happens in treatment” (-5) and statement 45 “I don’t seek help because there is no service available in my area” (-4); 6 “There are no treatment services available for me” (-4) and 48 “I don’t know where to seek treatment” (-3). They were the only group to disagree with statement 12: “I would prefer to speak to someone who could help me with all my problems” (-3). They were also the only group to receive bailout from family and friends, agreeing with statement 17 “I don’t need treatment because my family and friends will bail me out” (+4).

7.3.4 Factor D: Comorbid Issues

Problem gamblers loading upon Factor D (n=4) are three males and one female, who had a mean age of 18.25 years. Factor D explains 6% of the study variance and has an eigenvalue of 1.11.

7.3.4.1 Factor Interpretation

Problem gamblers loading upon Factor D agreed strongly with statement 2 “My family gambles a lot so I don’t think I have a problem” (+6). They also agreed with statement 25 “I don’t seek help for problem gambling because I am getting help for another problem” (+5). They agreed that they were reluctant to stop gambling because all their friends gamble and if they did so they would have no one to socialise with (1; +4). Unlike any of the other factors, Factor D were neutral about the statements “I don’t like talking about my problem” (40; 0) and “I don’t want to get any help” (5; 0). They were less concerned about the perceptions of others, strongly disagreeing with statement 36 “I’m worried what other people will think of me if I seek help” (-6) and disagreed that they would prefer to talk to

someone who has had a gambling problem (11; -5). They also, unlike other factors, disagreed that they had their problems under control by themselves (33; -2).

7.3.5 Consensus Statements

Although all four groups had different views on barriers to seeking help for their gambling problems, there were two consensus statements (see Table 18). All participants felt neutral about the statement 23 “I don’t need help with my gambling” and mildly disagreed with statement 35 “I am too ashamed to admit I have a gambling problem”.

Table 18: Consensus Statements

Statements	Factor A	Factor B	Factor C	Factor D
23 I don’t need help with my gambling	-1	0	1	0
35. I am too ashamed to admit I have a gambling problem	-2	-2	-2	-4

7.4 Discussion

Findings from this study appear to suggest that there are four different categories of young problem gambler who do not seek help. Analysis of the Q-sorts found four different factors which explained the subjective experiences and perceptions of barriers to treatment access amongst young problem gamblers. ‘*Stigma and Self-Awareness*’ was typified by feelings of shame, secrecy and embarrassment about seeking help for a gambling problem. Participants who loaded onto this factor experienced difficulties with talking about their problems, were worried about what others thought of them, and were keen to receive treatment from someone who had experienced a gambling problem. ‘*Denial and Treatment Resistance*’ was typified by not admitting they had a problem, not feeling that they needed treatment and saying that they didn’t have a gambling problem. Those who loaded onto the factor ‘*Peer pressure, Bailout and Reluctance to stop gambling*’ were the only ones agreeing that receiving help in the form of financial bailout from family and

friends could be a factor in their reluctance to seek help. This, along with social pressure to continue gambling, seems to engender reluctance amongst those in this factor to give up the perceived benefits of gambling. The final factor “*Comorbid issues*” is suggestive of gamblers who see gambling problems as existing secondary to other issues, for which they are already receiving help.

There were areas in which the four viewpoints were distinctly different from each other, most markedly so amongst those experiencing ‘*Stigma and Self-Awareness*’ and those experiencing ‘*Comorbid issues*’. While the former said that barriers to treatment seeking were that they would prefer to speak to someone who has experience with gambling problems, and were worried what others would think of them if they sought treatment, the latter disagreed. The former said that their families did not gamble a lot, whereas the latter agreed that they did. Finally, where the former disagreed with a barrier being that they didn’t like talking about their problems and disagreed that they didn’t want help, the latter were neutral on both. The viewpoints may be a function of whether the social environment of the participant was conducive to increased gambling behaviour. For example, it could be that those who loaded onto ‘*Stigma and Self-Awareness*’ perceived their gambling as shameful and problematic because their family did not participate in gambling, whereas those who loaded onto ‘*Comorbid issues*’ had family members who did gamble, which may have resulted in them perceiving their gambling to be less shameful and not being worried what others would think of them asking for help or talking about their problems.

Those experiencing ‘*Denial and Treatment Resistance*’ agreed that a barrier to treatment access was that they thought they had their gambling under control, whereas those experiencing ‘*Comorbid issues*’ disagreed with this. Perhaps those who had already sought

help for other issues were more able to admit that they had lost control of their gambling, whereas those resisting treatment needed to deny it.

There are distinct differences between the four viewpoints; however there are also areas of overlap. Both those experiencing *'Peer pressure, Bailout and Reluctance to stop gambling'* and *'Comorbid issues'* agreed with the suggestion that they would not seek treatment for gambling problems because all their friends gamble, and them stopping would mean they had no one to socialise with.

While there were no apparent gender effects which emerged during the analysis, as all three female participants loaded on to different factors, there could be interesting findings with regard age. The factor with the lower mean age (17.4 years) was *'Peer pressure, bailout and reluctance to stop'*, which makes intuitive sense given that perhaps the younger the gambler, the more likely that parents are to feel they need to provide funds and support to the problem gambler if they spend all their money or get into debt. Younger people may be more susceptible to peer pressure to continue gambling, and both this pressure alongside the fact that the implications of their gambling may be minimised due to bailout, may lead to an increased reluctance to stop gambling.

The factor with the highest mean age (18.75 years) was *'Denial and treatment resistance'*. Perhaps older problem gamblers are more likely to try and hide or minimise their problems, or inversely perhaps those who are still experiencing gambling problems in older adolescence and young adulthood do so because they have been able to hide and deny the problem effectively. It may be that this group have less trust in the abilities of treatment professionals to help and therefore resist seeking help. Interestingly, problem gamblers loading on to this factor strongly agreed with statement 22 "I told someone about my problem gambling but they didn't think it was an issue". It may be that for this group

the social construction of gambling as non-problematic may be a significant factor in treatment resistance.

A limitation of study 3b presented in Chapter 6 was that it did not access any participants who had not yet admitted they had a gambling problem, as all participants were recruited from either problem gambling discussion forums online, or directly from treatment organisations. For the study presented in this chapter, instructions did state that participants should not have sought formal help for their gambling problem, so they may have sought advice, information and support rather than treatment. This study appears to have overcome the limitation of the previous work, as the factor “*Denial and treatment resistance*” appears to include those for whom gambling is perceived as non-problematic and who strongly suggest they would not seek treatment.

A group that did not appear in study 3b were those for who gambling is a secondary issue. This group did appear in this research under the category “*Comorbid issues*”. This is a useful acknowledgement that this is an important group and that perhaps consideration needs to be given to ensuring that the treatment offered for comorbid issues also screens for and tackles issues with gambling.

Given that these factors were made up of statements derived from a concourse of previous literature and research findings, it is not surprising that each of the viewpoints have themes within them which are grounded in research evidence. A reminder of this evidence can be found in Appendix 2.

7.4.1 Limitations

Although the current study highlights that Q methodology is particularly appropriate for studying perceptions about barriers to treatment access among young problem gamblers,

the method does have its limitations. The difficulty in recruiting gamblers (Parke & Griffiths, 2002) and young people (Fargas-Malet, et al 2010; Munford & Sanders, 2004) to take part in research has been documented in the literature and was encountered in study 3b (Chapter 6). Therefore steps were taken during the course of this research to overcome the likelihood of recruiting a small sample of participants. The method was chosen not only for its ability to meet the research aims but because the subject under scrutiny is the Q-set, the statements which represent the breadth of opinion and feeling on the topic, rather than the participants themselves, and therefore small sample sizes are warranted, and should certainly be smaller than the number of statements in the Q-set, which in this case was 49. Stainton-Rogers (1995) suggests that an effective number of participants is for a Q study is between 40 and 60, however Watts and Stenner (2005) say this is only a “rule of thumb” and argue that “highly effective studies can be carried out with far fewer participants” (p.79). Jeffares and Skelcher (2010) suggest that Q studies might typically employ between 25 and 60 participants, however seminal work by Stephenson in Chapter 7 of *The Study of Behaviour* described two studies employing just 18 participants each. It is argued that there should be enough participants for four or five participants to load on to each viewpoint (van Exel & de Graaf, 2005) which was achieved in this study. Therefore the extent to which the study would have been improved by recruiting a large P-set may have been minimal. However it would be useful for further research to validate the accuracy of the factor solution reached.

The study was limited because it did not seek to include those young problem gamblers who had never sought any form of treatment, and exclude those who had taken least an initial step in seeking help for their gambling problem, as the study was advertised in both areas which were accessed by the general public and in areas where it would be seen by people seeking help for a gambling problem (problem gambling forums online). This

combined with the fact that the study asked for retrospective accounts of perceived barriers to treatment access may call in to question the validity of the factors which emerged from the study.

7.4.2 Further Work

An area for future investigation of this topic should be the confirmation of the factor structure reported in this study. Importantly, research should sample a larger number of female participants and explore factors based on participant variables such as age, gender, socio-economic status, and parental gambling. These variables would give us a greater understanding of the context within which these viewpoints develop, and allow inferences to be made to be about how best to overcome the perceived barriers to seeking help. This could then inform treatment providers, educators, and funding bodies, allowing them to develop the practical programmes of work required to encourage help-seeking behaviour in young people.

7.4.3 Conclusion

This study takes previous research a step further than identification of barriers to treatment access amongst young people, by not only ensuring that young problem gamblers themselves participated in the research, but also by employing a method which adds salience and meaning to the experience of those barriers. For the first time we have an understanding of how the previously identified barriers to treatment access may be experienced by different subgroups of young problem gamblers.

Chapter Eight: Conclusions, Implications and Recommendations

8.1 Introductory Restatement

The rate of problem gambling is over twice as high in adolescents as it is for adults (2%) (Ipsos MORI, 2009), and the younger the age of onset of problem gambling the more severe the problem can be in later life. Despite increasing awareness of problem gambling, the disorder remains largely undiagnosed and untreated because most problem gamblers do not seek treatment (Cunningham, 2005; Petry & Armento, 1999). It has been suggested that help-seeking is particularly uncommon amongst young people (Gupta & Derevensky, 2000; Haroon, Gupta & Derevensky, 2003) and a number of speculative reasons as why this may be have been suggested (Chevalier & Griffiths, 2004; Griffiths, 2001). However to date there is a paucity of empirical evidence which explore barriers to treatment access in young problem gamblers (Suurvali, 2009).

The aims of this thesis were to explore the attitudes and perceptions that young people hold towards problem gambling; to investigate the potential barriers which may prevent young people from seeking treatment; and to understand the salience of the identified barriers to treatment access amongst young problem gamblers. Studies 1 and 2 employed exploratory questionnaires to gather data with the aim of setting the research context, describing treatment availability for problem gambling through the NHS, and presenting a secondary analysis of an existing dataset to explore adolescent attitudes to gambling and perceptions of gambling related harm. Studies 3a and 3b employed in-depth interviews and thematic analysis to explore the perspectives of both problem gambling treatment specialists and young problem gamblers respectively. Study 4 employed Q methodology to draw together the findings from both published literature and the previous studies within this thesis to explore subjectivity of opinion on barriers to treatment access for

young people. This conclusion will draw together the key findings and their implications for understanding barriers to treatment access for young problem gamblers.

8.2 Original Contribution to Knowledge

This thesis makes an original contribution to knowledge by: identifying a number of new empirically grounded barriers to seeking treatment for young problem gamblers (emotional immaturity and poor verbal communication; lack of clinical skills in treatment providers; and lack of flexibility to suit client needs); and generating an empirical understanding on the subjective opinion on and salience of barriers to problem gambling help-seeking as they are experienced by young problem gamblers. Four groups of reasons for non-treatment seeking amongst young problem gamblers were identified: Stigma and Self-Awareness; Denial and Treatment Resistance; Peer Pressure, Bailout and Reluctance to Stop Gambling; and Comorbid Issues.

8.2.1 Main Findings

8.2.1.1 Lack of appropriate service provision

The survey of treatment provision presented in Chapter Four found that treatment for problem gamblers is generally not available on the NHS. While other agencies do provide treatment for problem gamblers, including for young problem gamblers specifically, the NHS is likely to be the first point of access for help about gambling problems through a GP. Griffiths (2007) recommended that services for problem gamblers should be provided by the NHS which are accessible and available in the gamblers local area. Six years after the publication of this report there is still no sign of this happening. In 2013, the provision of addiction services generally is moving from local NHS trusts into Health and Wellbeing boards which will be funded and managed by Local Authority areas. While this is intended to give more flexibility in service provision it may result in gambling being overlooked,

given funding constraints and the lack of health economic evidence available to support the direction of funding towards helping problem gamblers. One finding from the study presented in Chapter Four was that often, NHS trusts did not acknowledge problem gambling as a mental health difficulty. It is a major concern and a significant barrier to providing services that this perception still permeates.

8.2.1.1.1 Faulty perceptions of service provision

Throughout the qualitative stages of this research it was evident that young people often did not know what treatment would involve and had concerns about whether they might have to discuss problems in groups, concerns about privacy and confidentiality, and had expectations about treatment which, when they were not met, may result in drop out. Young people who took part in study 3b (see Chapter Six) highlighted particular concerns about group treatment, online treatment, and confidentiality. This was confirmed as an important influence on those represented by the viewpoint ‘Denial and Treatment Resistance’ identified in study 4. Tackling this lack of awareness about the treatment options available, and ensuring amongst treatment seekers an understanding of the expectations from them, and what they can expect from service provision, is of vital importance in encouraging young problem gamblers to seek help.

8.2.1.1.2 Lack of appropriate clinical skills and flexibility

A novel finding from this research was that clinicians themselves may not feel empowered to offer help to young people and therefore this could act as a barrier to treatment access. It was reported that there are particular skills necessary to engage young people, and particular types of treatment which best suit young people, which clinicians either did not have or felt unable to provide, due to a lack of training or constraints placed upon them by the services they worked for.

8.2.1.2 Lack of awareness about gambling problems

A major finding from this research programme was that young people are generally unaware that gambling can be problematic. The secondary analysis of data presented in Chapter Five highlighted that informal gambling amongst friends was not considered to be a separate form of gambling. Given that informal gambling is the second most prevalent form of gambling in which young people engage (Ipsos MORI, 2009) this is a concern: the harms of informal gambling may not be realised if it is not perceived as ‘real’ gambling. The secondary data analysis also highlighted that young people generally do not recognise many of the signs of being a problem gambler. Less than one in ten would think that behavioural and emotional changes could indicate a gambling problem, and none recognised the DSM-IV constructs of Chasing; Progression; Tolerance; Escape or Deception.

8.2.1.2.1 Denial

The lack of awareness that gambling was problematic was a theme throughout each stage of the research, being identified by problem gambling treatment providers as a reason for young people not seeking help, by young problem gamblers themselves as causing difficulties in recognising their own problems and for others to recognise the seriousness of the issue, and emerged as a defining characteristic in two groups of non-treatment seekers: ‘*Denial and Treatment Resistance*’ and ‘*Comorbid Issues*’.

8.2.1.2.2 Lack of awareness about how to help

Given the hypothetical scenario of having a friend with a gambling problem, young people were most likely say they would try to help that friend themselves, by either talking to them, keeping them away from gambling premises or activities. The findings presented in Chapter Five (Study 2) suggest that only one in five would encourage their friend to seek

formal help and just 1% would tell someone in a position of authority such as a parent or a teacher.

8.2.1.2.2.1 Parental bailout

Receiving financial bailout from parents (or other family or friends) was found to be a key reason why young people might not seek treatment for gambling problems. It was identified as an important factor by both clinicians and young problem gamblers during studies 3a and 3b, and formed a major defining factor of a group of non-treatment seekers discovered in study 4: those affected by '*Peer pressure, Bailout and Reluctance to stop gambling*'. Increasing parental awareness that financial bailout is not likely to fix gambling problems, rather it may extend them, is likely to be a useful aim with regards encouraging treatment seeking behaviour.

8.2.1.3 Stigma of admitting problems and seeking treatment

Seeking help for a gambling problem is seen as stigmatising for young people. Participants in study 3b reported that their peers laughed at them when they talked about their problem, and a common theme throughout the research was that gambling to excess was somehow shameful and something to be kept secret and hidden from family and friends. Concerns about stigma associated with seeking help are a major definer of a group of non-treatment seekers found in Study 4 (see Section 7.3.1 '*Stigma and Self-Awareness*').

8.2.1.4 Difficulties for young people engaging in treatment

A concept which has not previously been explored was that of the link between emotional immaturity, poor verbal communication skills and low uptake of treatment and treatment drop out. This was a concept which was, unsurprisingly, only identified by problem gambling treatment providers, as those young people taking part in the qualitative research

were likely to have had more confidence in their verbal ability. It may be that treatment options with less emphasis on verbal ability should be explored as options for young problem gamblers.

8.2.1.5 Comorbid issues

Young people may not seek treatment for problem gambling if they have comorbid problems which either take priority as a concern, or are being treated elsewhere. This was suggested as a barrier to accessing treatment by clinicians in study 3a and was confirmed as a major descriptor of a factor '*Comorbid issues*' identified in study 4. This has important implications for how other non-problem gambling services may treat the issue. It is important that questions about gambling are asked by other services that young people might access for help. Often gambling is not screened for as part of an assessment when accessing health and mental health services, and if questions are not asked it is unlikely that young people will volunteer information about problematic gambling, given the lack of priority this group afford the issue.

8.3 Recommendations

This research has flagged a number of important areas which could be addressed by a range of service providers in the UK. A major issue which must be tackled is the general and specific lack of awareness amongst people in the UK, and amongst young people and those who care for them in particular, about: what gambling is; what harms may be associated with gambling; how these harms might be identified; how to offer support; and how and where to seek professional help. These issues were identified throughout the thesis: Chapter Five highlighted that peers are unlikely to know how to spot a gambling problem; Chapter Six identified that neither professionals nor parents often have conversations about gambling and the potential problems it may cause. Alongside the

issue of awareness, as suggested in Chapter Six, it is important that appropriate and accessible services are offered for young people, which take into account not only the needs of young people but also the training needs of the individual treatment providers offering those services. These recommendations will be discussed in more detail below, and where applicable reference is made to the page number within the thesis where the original evidence on which the recommendation is based can be located.

8.3.1 Awareness of Gambling and Problem Gambling

This research has identified a range of areas in which awareness might usefully be raised to tackle the low rate of treatment seeking found in young problem gamblers (what gambling is [p.89; p.108]; what harms may be associated with gambling [p.108; p.143; p.165]; how these harms might be identified [p.168]; how to offer support [p. 147; p.200]; and how and where to seek professional help [p.89; p. 189]). This awareness raising work could be undertaken in a variety of settings to reach a range of important groups. Those groups most important to reach are likely to be young people; parents and other caregivers; other professionals; and the general public.

8.3.1.1 Young People

Awareness raising work about gambling and problem gambling could usefully be done in schools given that the majority of young people attend full time education. Gambling is not currently specified in any curriculum areas as a topic that should be discussed with young people during their secondary or post-16 education. The PSHEe (Personal, Social, Health, Emotional and Economic) education curriculum does offer gambling as a suggestion for a topic used to explore risk, but this is not required. There was a strong perception amongst participants interviewed in study 3b that had they received education

about gambling in school they might have realised they had a problem sooner, or not begun gambling at all.

A problem with introducing problem gambling onto the curriculum is that teachers often feel time pressures and may be unable to fit another topic in to their programme of teaching, or they may not feel equipped to discuss gambling with their students as they may not have a good level of awareness about the issue themselves. Without proper evidence that education in schools about gambling makes a useful impact in terms of reduction of gambling related harm, it may be difficult to argue that it has a place. Further arguments against introducing a school based curriculum may be that the groups most likely to be at risk for developing gambling problems may not be present in the school setting: problem gambling is linked to truancy and poor educational attainment.

One of the most important outcomes of the programme of research carried out to inform this thesis was that the work came to the attention of the trustees and Chief Executive of GamCare (the national charity providing advice, information and treatment for anyone affected by gambling problems) via the research carried out with their clinical staff in study 3a. After discussions about the importance of the findings of this research, the author was offered a role within the organisation to set up a Youth Service, aimed in the first instance at providing education to young people and later providing treatment services where necessary. External funding was sought using evidence from the programme of research presented in this thesis, and a substantial grant was awarded by the Esmee Fairbairn Trust to carry out an action research programme, aimed at education and awareness raising work alongside brief intervention services within schools and colleges and other youth service settings in Bristol. This work will culminate in 2015 and will add important evidence about how best to approach awareness raising in young people.

The Bristol Programme has incorporated evidence from this research in its design, and education sessions will contain information about how to spot gambling problems in peers, particularly focusing on those areas which were not identified by the adolescents who took part in study 2 (chasing, deception, progression, tolerance and escape).

8.3.1.2 Parents

Parents play a vital role in both the formation and cessation of gambling problems [p. 157; p. 189]. It is well documented that parental gambling problems are related to the development of gambling problems in their children. Important barriers have been identified which link to parental attitudes to gambling – they may be gamblers themselves and therefore minimise the impact of the behaviour of their child, viewing problematic behaviour as ‘normal’ rather than identifying early that it may be a cause for concern. Conversely parents may identify that their child has a problem and offer them financial bailout, not realising that this may in fact prolong their experience of the problem. They may also fail to recognise completely the signs of problem gambling and be unaware that it is causing their child difficulty. Therefore the education of parents and caregivers is vital to not only help them identify the problem, but also to intervene appropriately if they suspect there is an issue. This could be usefully achieved by including information about gambling problem in parenting classes aimed at those from ‘at risk’ groups, or via schools in the form of information sessions or leaflets.

8.3.1.3 Other professionals

Professionals not involved with the treatment of problem gamblers should be made aware that problem gambling may be an issue for the clients they see (p.190). Other addiction services could usefully screen for gambling problems as part of their initial assessment, and ensure that problem gambling behaviour is taken in to account as part of recovery.

GPs should also be made aware of the signs and symptoms of problem gambling behaviour in young people. They should also be informed about where to direct young people for appropriate help. The funders of this research, The Responsible Gambling Trust, are currently also funding a range of Gambling Risk and Harm Minimisation (GRaHM) Projects and a project working with the Royal College of GPs to look at ways of increasing knowledge of problem gambling amongst professionals working in other services. The outcomes of this work will be interesting to those concerned with barriers to treatment access for young people.

8.3.1.4 General Public

Efforts should be made to increase awareness amongst the general public that young people can suffer from gambling problems, and increase awareness about appropriate avenues for seeking help (see p.199). If more people are aware that gambling can be problematic, young people are more likely to be urged to be cautious with gambling, and where problems develop, to seek help sooner. Given that problem gambling severity is linked with an earlier onset of gambling participation (Rahman et al, 2012) this is likely to be important in combatting problem gambling.

8.3.2 Provision of Appropriate Treatment

A lack of appropriate treatment, or the perception that this may be the case, has been identified as a potential barrier to seeking treatment in studies 3a and 3b by both clinicians and young problem gamblers, and in study 4 was an important theme in both “*Stigma and Self-Awareness*” and “*Denial and Treatment Resistance*”. It is important that appropriate and accessible services are offered for young people, which take into account not only the needs of young people but also the training needs of the individual treatment providers offering those services.

8.3.2.1 Youth Appropriate Services

In order to reduce or remove the barriers to seeking help for young problem gamblers it is essential that treatment services are appropriate for young people. Services, whether generic or specifically for young people, need to provide clear accessible information about exactly what treatment involves. Young people may be nervous or have misperceptions about what treatment involves. Common perceptions are that they will be required to stand in front of a group and talk about their problems. There are likely to be concerns about the cost of treatment, what is required of them, and what they can expect from the service. This information should be provided in such a way that young people do not have to approach the service itself for information, for example via the services website. Young people often use the internet to search for information online and use this as a way to inform decision making about treatment seeking. Therefore easily accessible, clear, and comprehensive information provision is likely to reduce barriers for young people seeking help.

8.3.2.1.1 Drop In (peer support/comparison)

Drop in services may be particularly appropriate for young people experiencing problems with gambling. A key theme identified in study 3b was the desire to speak to other young people experiencing gambling problems, to talk about what they are going through but also as a way of comparing the ‘size’ of their problem to others. However, group settings were described as off-putting for young people who were not keen to talk about their issues in front of a group. Therefore offering drop in sessions as part of a programme of treatment to enable young problem gamblers to meet others may provide a valuable avenue of peer support. This must however be carried out with caution to ensure it does

not provide young gamblers with a supportive network of friends who may encourage each other in the behaviour.

8.3.2.1.2 Online Services

Online provision of information and services may be a useful avenue to offer treatment which reduces the barriers to help-seeking for young problem gamblers. However such services will need to ensure confidentiality and privacy or anonymity for young problem gamblers who seem particularly concerned about disclosing information about their gambling problem online in case other people find out about it and trace it back to them (see p.153).

Providing information and case studies online about young problem gamblers may be useful as there was a desire to compare their behaviour with others. This would be more effective if the case studies were first-hand accounts from young problem gamblers themselves. Again, this was an important outcome from this programme of research, as in the role of Head of Youth Services at GamCare the author was able to secure external funding for a dedicated information site for youth problem gambling using evidence gathered during the empirical studies conducted. This site was launched in November 2012 at www.bigdeal.org.uk, and early analysis shows that it is having an impact by encouraging young people to contact GamCare's telephone helpline and internet chat services for advice about their gambling problems.

It must be noted that such provision of online services may in fact mask the rate of help-seeking in young people; it may be that seeking informal help and guidance online is enough to help them overcome their gambling problems without seeking formal, professional treatment. This is an area which warrants further research attention.

8.3.2.2 Training for service providers

Treatment providers who offer services for young problem gamblers should receive the appropriate training and support to be able to offer such services (see p.137). Currently it appears that there are two models of treatment provision in the UK: specialist problem gambling services which offer treatment to adult problem gamblers; and generic youth services who offer generic treatment to young problem gamblers. It may be that special training is needed to ensure that these groups both have the skills and knowledge required to work with young people and with problem gamblers. Such services may then improve confidence in their service offering and encourage young people to seek their help.

8.4 Methodological Limitations

The difficulties of recruiting gamblers to research have been usefully highlighted by Parke and Griffiths (2002) who argue that this is a particularly difficult population to study. They suggest a number of reasons as to why this may be the case, and the following may be relevant to research with young problem gamblers:

- Activity engrossment. Gamblers may become so fixated on gambling that they ‘tune out’ almost everything else around them;
- Fear of ignorance. Gamblers may worry that they will get found out for not knowing very much about gambling, and could therefore be reluctant to participate in research;
- Guilt and embarrassment. This is a particular concern for research exploring barriers to treatment access, as one of the functions of experiencing such a barrier may also act as a barrier to participating in research;

- Infringement of anonymity. Many gamblers partake in gambling activities as a means of escape. They may not wish to partake in any research which could infringe upon this;
- Unconscious motivation and lack of self-understanding. Many gamblers may not understand the reason why they behave the way they do, therefore articulating this accurately to researchers can be difficult;
- Lack of incentive. Some gamblers may refuse to take part in research because they feel there is nothing in it for them.

These reasons go quite some way to explaining why it was difficult to recruit young problem gamblers to the research programme, as the barriers to participating in research closely mirror the suggested barriers to problem gambling treatment access.

8.5 Final remarks

Many adult problem gamblers begin their gambling careers in their youth. Younger people have been shown to be at a higher risk for developing gambling problems (Ipsos MORI, 2009; Wardle et al, 2011) and may have been introduced to gambling by family and friends, who often portray it as a harmless activity. Only 5% of parents would ever take steps to stop their children from gambling (Ladouceur et al, 1999). Those young people who do develop gambling problems very rarely seek help. The program of research presented in this thesis has identified and empirically grounded a number of barriers to treatment access perceived by young problem gamblers, and has described four different perspectives on why problem gamblers might find it difficult to seek help. These findings can be used to inform education and service provision in a number of ways. Raising awareness of gambling and gambling related harm may reduce the stigma associated with gambling problems; encourage young people to resist peer pressure to continue gambling;

and facilitate family members or peers to provide appropriate help, and avoid inappropriate strategies such as providing financial bailout. Altering the way in which treatment services present and deliver those services to young people may encourage young people to overcome their resistance to seeking treatment, and when the issue is comorbid, services may be able to ensure appropriate care and support is given for gambling alongside other problems.

This thesis informs the area of barriers to treatment access amongst young problem gamblers and suggests ways in which young people can be encouraged to overcome perceived barriers to seeking help. However it also raises a number of areas in which further exploration is urgently needed. It is hoped that in addition to the two areas highlighted in which findings from this research are already being implemented by service providers (school based education and online information provision in the UK) that the recommendations will be noted and implementation of these explored by all stakeholders, including funding bodies, research institutions other addiction and mental health services, not just those currently providing problem gambling treatment services.

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APPENDICES

Appendix 1: Responses to Questionnaire in Study 2

Question	Response category	Response examples
1: Write down a few words that come into your head when you think about the word 'gambling'	Winning prizes/money	"Win"; "Winner"; "Jackpot"; "Prize";
	Type of gambling	"Lottery"; "Scratchcard"; "Machine"; "Fruities"; "Slots"
	Negative consequences	"Bad"; "Dangerous"; "Lose"; "Debt"; "Lose everything"
	Gambling Venue	"Casino"; "Bookies"; "Races"
	Gambling Location	"William Hills on Duke Street"; "Lottery at the newsagents"
	Gambling word (e.g. bet)	"Bet"; "Wager"; "Odds"; "2/1"
	Gambling item (e.g. chip)	"Chip"; "Playing cards"; "Ace"; "Nudge button"
	People	"Uncle Tom"; "Grandad";
	Emotion	"Exciting"; "Scary"; "Thrill"; "Rush"
	Other	"James Bond"; "Flashing lights and sounds"
2: What types of gambling have you heard about?	Poker	"Poker"
	Non-poker card games	"Blackjack"; "Aces high"
	Horse Racing	"Horses"; "Horse racing"
	Slot Machines	"Machines"; "Fruities"; "Slots"
	Casinos	"Casino"
	Lotteries	"Lottery"; "Euromillions"

	Roulette	“Roulette”
	Sports Betting	“Football bets”; “Bets on sports”; “Cricket betting”
	Dog Racing	“Dogs”; “Greyhound racing”
	Arcade Gambling	“Arcades”; “Amusements”; “Penny falls”; “Ticket machines”
	Bingo	“Bingo”
	Internet Gambling	“Internet gambling”; “Internet poker”; “Online bingo”
	Bookmakers	“Bookies”; “Bookmakers”
	Scratchcards	“Scratchcards”; “Scratchies”; “Scratch tickets”
3: At what age do you think you are allowed to gamble?	18	“18”
	16 lottery, 18 generally	“Lottery at age 16 but everything else at 18”
	21	“21”
	Any age	“When you are born”; “At any age”; “Whenever you want”
	16	“16”
	Other	“I think never”; “3”; “When you are not a child anymore”
4: Why do you think some people choose to gamble?	Win money	“To win big!”; “Get money”; “To get rich”
	Fun/enjoyment	“Fun”; “They enjoy it”; “It’s fun to do”
	Excitement	“Exciting”; “It’s a thrill”;

		“For the rush”
	Poor/not rich	“They need money”; “They haven’t got enough money”; “They need to pay people back”
	Bored	“Nothing else to do”; “Bored”
5: Why do you think some people choose not to gamble?	Avoid debt	“So they don’t get in debt”; “So they don’t have to remortgage their house”; So they don’t spend all they have and then they need to borrow it all”
	Fear of addiction	“Addictive”; “Don’t want to get addicted”; “Scared of getting hooked”
	Too risky	“Not worth a risk”; “Dangerous”
	Sin	“It’s against their religion”; “It’s a sin”
	Not likely to win	“You won’t win anyway”; “The house always wins”
	No fun/boring	“It’s very dull”; “Not fun for them”; “It’s too boring”
	6: What do you think about people who gamble?	Negative
Up to the individual		“It’s up to them”; It’s their choice”
Bad people		“Criminals”; “They are gangsters”; “It is bad to do”
Exciting		“Brave”; “Cool guys”; “They are exciting people to know”
OK in moderation		“It’s ok if they keep it in

		check”; “So long as they just gamble a bit it is fine”
	Normal	“Average guys”; “Just normal people”; “No different to anyone else”
	Feel sorry for them	“It’s a shame for them”; “Feel sorry for them - they don’t understand they won’t win”; “I want to help them”
	They are rich	“Millionaires”; “They must have a lot of money”; “Rich”
7: What might be some of the problems that could happen because of gambling?	Lose money	“They could lose all their money”; “They would be poor”
	Addiction	“They could get addicted”; “They might not be able to stop”
	Debt	“They would get in with loan sharks”; “They have too much to pay back”; “Debt”
	Behavioural/emotional/alcohol problems	“They would drink too much”; “Angry”; “They would be depressed” “Stressed out”
	Crime	“Stealing” “Going to prison”
	Death	“They would get killed”;
	Relationship problems	“They might break up”; “Their wife would leave”; “No friends”
8: How would you know if a friend had a problem with	Gambling all the time	“Always want to go gambling”; “They are

their gambling?		always on the machines”
	Rich	“They will have lots of money”; “They will have money all the time”; “More money than they can explain”
	Spending everything at once	“Never have money even if they only just got their pocket money”; “Always spend everything at once”
	No money/possessions	“Never have any money”; “Selling everything”
	Borrowing	“They would always be asking for money”; “They would ask to borrow off me”
	Behavioural/emotional changes	“Would be sad all the time”; “Would be angry”; “Would stop hanging out”
	Talking about gambling	“Always talking about it”; “Not talking about anything else”
	I wouldn’t know	“I wouldn’t be able to tell”; “Couldn’t know unless they told me”
	Crime	“Stealing”; “In trouble with police”
	They would tell me	“They would just tell me about it”; “They might come to me for help”
9: What could you do to help a friend who had a problem with their gambling?	Keep away from gambling premises/activities	“Stop them going there”; “Don’t let them in”
	Keep their money	“Take their money away”; “Keep their wallet”
	Tell someone	“Tell their mum”; “Tell the

		teacher”
	Talk to them	“Get them to talk about it”; “Talk about it and see how to help”
	Distract them	“Do other things with them”; “Take them to the cinema”; “Go out somewhere else”
	Lend money	“Give them more money”; “Lend them my money”
	Take to treatment	“Get them to see a psychiatrist”; “Get them to the doctor”; “Ring a counsellor”
	Hit them	“Beat them up”; “Smack them”
	Do not know	“I don’t know”; “No idea”
	Can’t do anything	“Nothing would help”; “I couldn’t do anything”
10: Anything else you wish to say about gambling?	I will not gamble	“Gambling is for mugs”; “People should never do it”
	Nothing	Blank; “No thanks”
	Gambling is good/cool	“Awesome!”; “Gambling is cool”

Appendix 2: Q-set with justification

1. All my friends gamble so if I stopped I would have no one to socialise with.
 - Gambling is cool – having problems not (research findings study 3a and 3b)
 - Peer pressure (Chevalier & Griffiths, 2004; Griffiths, 2001;)
 - Pressure from others to continue gambling (Piquette-Tomei, Dwyerm Norman, McCaslin & Burnet, 2007)
2. My family gambles a lot so I don't think I have got a problem
 - Pressure from others to continue gambling (Piquette-Tomei, Dwyerm Norman, McCaslin & Burnet, 2007)
 - Family correlate of problem gambling (Ladouceur & Mireault, 1998; Gambino, Fitzgerald, Schaffer, Renner & Courtenage, 1993; Becona et al, 1995; Winters et al, 1995; Gupta & Derevensky, 1997; Wood & Griffiths, 1998; Jacobs, 2000; Felshner et al 2003; Delfabbro et al, 2005)
3. I don't want to give up the financial rewards of gambling
 - Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)
4. I need to keep gambling to win back my losses
 - Not aware of the problems related to chasing (research findings study 2)
5. I don't want to get any help
 - Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)
 - Shame, secrecy, embarrassment, pride and fear of stigma (Hodgins & el-Guebaly, 2000, Tavares et al, 2002; Cooper, 2001, 2004; Rockloff & Schofield, 2004; Evans & Delfabbro, 2005; Pulford e al, 2009)
6. There are no treatment services available for me

- Clinicians (research findings study 3a) suggest lack of awareness about treatment availability a major barrier to accessing treatment
 - Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Rockloff & Schofield, 2004; Pulford et al, 2009)
7. I can't get to treatment for problem gambling
- Lack of local service (Clinician's study 3a)
 - Lack of funds to travel to services (Clinicians study 3a)
8. Treatment would be too expensive for me
- Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Rockloff & Schofield, 2004; Pulford et al, 2009)
9. problem gambling treatment is not designed for young people
- Clinicians (study 3a) suggest problem gambling treatment not tailored for young people and they may feel threatened/uncomfortable
 - Problem gamblers study 3b
 - Concern about what goes on in treatment/quality/efficacy (Hodgins & el-Guabaly, 2000; Rockloff & Schofield, 2004; Pulford et al, 2009)
10. I wouldn't fit in at problem gambling treatment
- Anecdotal (gamcare forum/contacts with pg's not through research) suggests that treatment would be difficult to engage in because they don't feel comfortable talking about it
 - Clinicians (study 3a) suggest problem gambling treatment not tailored for young people and they may feel threatened/uncomfortable
 - Concern about what goes on in treatment/quality/efficacy (Hodgins & el-Guabaly, 2000; Rockloff & Schofield, 2004; Pulford et al, 2009)
11. I would prefer to talk to someone who has had a problem
- Clinician's chapter – kids may not feel like an adult therapist can really identify with them

12 I would prefer to speak to someone who could help me with lots of problems not just gambling

- Clinician's chapter – kids may not feel like an adult therapist can really identify with them
- Shame, secrecy, embarrassment, pride and fear of stigma (Hodgins & el-Guebaly, 2000, Tavares et al, 2002; Cooper, 2001, 2004; Rockloff & Schofield, 2004; Evans & Delfabbro, 2005; Pulford et al, 2009)
- Anecdotal (gamcare forum/contacts with problem gamblers, not through research) suggests that treatment would be difficult to engage in because they don't feel comfortable talking about it
- Clinicians (study 3a) suggest problem gambling treatment not tailored for young people and they may feel threatened/uncomfortable
 - Concern about what goes on in treatment/quality/efficacy (Hodgins & el-Guebaly, 2000; Rockloff & Schofield, 2004; Pulford et al, 2009)

13. I would prefer to talk to a problem gambling specialist

- Reverse item - Clinicians (study 3a) suggest problem gambling treatment not tailored for young people and they may feel threatened/uncomfortable

14. I would prefer to get help online

- Anecdotal (gamcare forum/contacts with pg's not through research) suggests that treatment would be difficult to engage in because they don't feel comfortable talking about it
- Clinicians (study 3a) suggest problem gambling treatment not tailored for young people and they may feel threatened/uncomfortable
- Young people more used to accessing services and communicating online
- few local services available (NHS chapter, Clinician's chapter)
- Lack of suitable treatment services for young people (Chevalier & Griffiths, 2004; Griffiths, 2001)

15 I would prefer to go to get treatment in a group with other people my age

- Lack of suitable treatment services for young people (Chevalier & Griffiths, 2004; Griffiths, 2001)

16. I would prefer to get treatment by speaking to a therapist face to face

- Reverse item: Lack of suitable treatment services for young people (Chevalier & Griffiths, 2004; Griffiths, 2001) exploring the perception that face to face counselling isn't what young people want
- Problem gamblers reluctant to seek help online (study 3b)

17. I don't need treatment because my parents and friends will bail me out

- Chevalier & Griffiths, 2004; Griffiths, 2001; Turner & Lieu 1999

18. All my friends gamble as much as me and we don't need help

- Social acceptability (Gupta & Derevensky, 2000)
- Gambling socially constructed to be non-problematic (Chevalier & Griffiths, 2004; Griffiths, 2001)

19. I don't want to stop gambling

- Gambling is cool – having problems not: Clinicians chapter 5
- Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)
- Pressure from others to continue gambling (Piquette-Tomei, Dwyerm Norman, McCaslin & Burnet, 2007)

20. I enjoy gambling so I don't want to seek help

- Gambling is cool – having problems not: Clinicians chapter 5
- Peer pressure (Chevalier & Griffiths, 2004; Griffiths, 2001)
- Pressure from others to continue gambling (Piquette-Tomei, Dwyerm Norman, McCaslin & Burnet, 2007)

21. Problem gambling isn't very serious

- Young people fail to acknowledge gambling as a problem and minimize the concept of harm relating to problem gambling (Ladouceur, Blaszczynski & Petteliet, 2004)
22. I told someone about my problem gambling but they didn't think it was an issue
- GP's/teachers/parents don't know that specialist help available (gamcare)
 - social acceptability of gambling (Gupta & Derevensky, 2000)
23. I have too many other problems to worry about gambling
24. I have too many other problems to worry about gambling
- Adolescents may seek help for another problem before getting help for problem gambling (Chevalier & Griffiths, 2004; Griffiths, 2001)
25. I don't seek help for problem gambling because I am getting help for another problem
- Adolescents may seek help for another problem before getting help for problem gambling (Chevalier & Griffiths, 2004; Griffiths, 2001)
- 26 I would be able to tell a friend if I had a gambling problem
- Reversed item: social acceptability of gambling (Gupta & Derevensky, 2000)
 - Gambling is cool – having problems not: Clinicians chapter 5
 - Shame, secrecy, embarrassment, pride and fear of stigma (Hodgins & el-Guebaly, 2000, Tavares et al, 2002; Cooper, 2001, 2004; Rockloff & Schofield, 2004; Evans & Delfabbro, 2005; Pulford et al, 2009)
27. I can get help to stop gambling from my family so I don't need to seek treatment
- Parental bailout (Chevalier & Griffiths, 2004; Griffiths, 2001)
28. I gamble a lot by choice, not because I am addicted
- Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)
29. I gamble more than I want to but my problem really isn't that bad
- Young people fail to acknowledge gambling as a problem and minimize the concept of harm relating to problem gambling (Ladouceur, Blaszczynski & Petteliet, 2004)

- Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)

30. Other people want me to get treatment but I don't think I need it

- Young people fail to acknowledge gambling as a problem and minimize the concept of harm relating to problem gambling (Ladouceur, Blaszczynski & Petteliet, 2004)
- Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)

31. I don't need treatment

- Young people fail to acknowledge gambling as a problem and minimize the concept of harm relating to problem gambling (Ladouceur, Blaszczynski & Petteliet, 2004)
- Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)

32. I wouldn't seek any treatment for a problem that isn't physical

- General population tends not to seek help for mental health problems (Hornblow, Bushnell, Wells, Joyce & Oakley-Browne, 1990; Lin, Goering, Offord, Campbell & Boyle, 1996)

33. I have my problems under control by myself

- Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)

34. I haven't got time to go for treatment

- Young people have too much else going on to get help – even if they seek help they may not show up because “something came up” (clinician's study 3a)
- Lack of suitable treatment services for young people (Chevalier & Griffiths, 2004; Griffiths, 2001)

35. I am too ashamed to admit I have a gambling problem

- Anecdotal (gamcare forum/contacts with pg's not through research) suggests that treatment would be difficult to engage in because they don't feel comfortable talking about it
- Clinicians (chapter 5) suggest problem gambling treatment not tailored for young people and they may feel threatened/uncomfortable

- Concern about what goes on in treatment/quality/efficacy (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)

36. I am worried what other people will think of me if I seek help

- Gambling is cool – having problems not: Clinicians study 3a, Problem gamblers study 3b
- Shame, secrecy, embarrassment, pride and fear of stigma (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000, Pulford e al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002)

37. I would never admit to having a gambling problem

- Shame, secrecy, embarrassment, pride and fear of stigma (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000, Pulford e al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002)

38. I wouldn't trust a counsellor not to tell my family

- Shame, secrecy, embarrassment, pride and fear of stigma (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000, Pulford e al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002)

39 People will find out if i start getting treatment

- Shame, secrecy, embarrassment, pride and fear of stigma (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000, Pulford e al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002)

40. I don't like talking about my problems

- Shame, secrecy, embarrassment, pride and fear of stigma (Cooper, 2001, 2004; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000, Pulford e al, 2009; Rockloff & Schofield, 2004; Tavares et al, 2002)
- Not emotionally mature enough (clinician's chapter)

41. I struggle to tell people how I feel

- Not emotionally mature enough (clinician's chapter)

42. Treatment wouldn't work for me

- Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)
- Concern about what goes on in treatment/quality/efficacy (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)

43. Treatment doesn't work for anyone

- Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)

44. I'm too young to have a real gambling problem

Young people fail to acknowledge gambling as a problem and minimize the concept of harm relating to problem gambling (Ladouceur, Blaszczynski & Pettelier, 2004)

Denial (Chevalier & Griffiths, 2004; Griffiths, 2001)

45. I don't seek help because there is no service available in my area

- Clinicians (chapter 5) suggest lack of awareness about treatment availability a major barrier to accessing treatment
- Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)
- GP's/teachers/parents don't know that specialist help available (gamcare)

46. I am too proud to admit I have a problem

- Belief amongst problem gamblers that they can handle their problems themselves (Boughton & Brewster, 2002; Evans & Delfabbro, 2005; Hodgins & el-Guabaly, 2000; Nova Scotia Dept of Health, 2001; Pulford, Bellringer, Abbott, Clarke, Hodgins & Williams, 2009; Tremayne, Masterman-Smith, & McMillen, 2001; Tavares, Martins, Zilberman & el-Guabaly, 2002)

- Anecdotal (gamcare forum/contacts with pg's not through research) suggests that treatment would be difficult to engage in because they don't feel comfortable talking about it
- Clinicians (chapter 5) suggest problem gambling treatment not tailored for young people and they may feel threatened/uncomfortable
- Gambling is cool – having problems not: Clinicians study 3a

47. I don't know what happens in treatment

- Clinicians (study 3a) suggest lack of awareness about treatment availability a major barrier to accessing treatment
- Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)

48. I don't know where to seek treatment

- Clinicians (chapter 5) suggest lack of awareness about treatment availability a major barrier to accessing treatment
- Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)
- Not talked about in schools (GamCare, clinician's study 3a)
- GP's/teachers/parents don't know that specialist help available (gamcare)

49 I don't know who to tell about my gambling problem

- Clinicians (chapter 5) suggest lack of awareness about treatment availability a major barrier to accessing treatment
- Lack of knowledge about treatment options (Hodgins & el-Guabaly, 2000; Pulford et al, 2009; Rockloff & Schofield, 2004)
- Parents unlikely to discuss problem gambling (Ladouceur et al, 1998)

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