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ORIGINAL ARTICLE

Narratives of reduction and change among patients of an internet-delivered therapy for gambling harm

Fabio Lucchini[1] · Mark D. Griffiths[2]

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Abstract

Aim Shame and fear of stigma represent barriers which prevent many gamblers from seeking help. To overcome some of these obstacles, new types of professional help have emerged, based on use of telephone and information technology. The aim of this study was to offer an overview of the characteristics of high-risk gamblers who entered an internet-delivered therapy program, and provides a typology of such patients through their narratives of gambling reduction and change.

Subject and methods Of the 4742 gamblers (83.4% males) who accessed internet-delivered therapy in Italy, the present study focuses on the 784 gamblers who began the therapy and the 177 gamblers (22.6%) who completed the treatment. By utilizing a mixed-methods approach, the present study describes the socio-economic and gambling characteristics of patients and identified outcome predictors.

Results Compared to treatment completers, treatment dropouts had a higher propensity to use non-strategy-based games, gamble more frequently, and have a shorter history of gambling and problem gambling. The study also examined the stories of high-risk gamblers who successfully completed the therapy. Four different types of gamblers in treatment — 'compliant', 'autonomous', 'erratic', and 'fragile' — were identified.

Conclusion The results of this study reflect the complex intertwining of individual agency and structural conditions that may affect the outcome of a therapy, providing a first insight into new ways to analyze help-seeking behavior and recovery from gambling harm.

Keywords Agency · Gambling · Patients · Internet-delivered therapy · Narratives · Change

Introduction

Gambling can be represented as a complex social behavior that can have significant impacts on individuals and result in problem gambling for a minority of individuals. In a comprehensive review, Neal et al. (2005) defined problem gambling as being *"characterized by difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community"* (p. i). On the one hand, increased opportunities for gambling, targeted advertising strategies, and diffusion of new technologies make gambling experience both easier and potentially harmful. On the other hand, widespread awareness of gambling-related harms can push many individuals towards more reflexive behaviors and engage institutions in efforts to prevent and mitigate side effects (Gabellini et al. 2022). In discussing the process of 'gambling rationalization' and its harmful effects, Cosgrave (2022) describes the consolidation over time of a 'problem gambling knowledge' used by counselors and treatment centers to address gambling disorders in the community.

In the present paper, the concepts of 'gambling harm' and 'high-risk gamblers' are used in order to avoid labelling and stigmatization effects (Livingstone and Rintoul 2021). High-risk gamblers do not always recognize the critical situation they face. It is often relatives, friends, colleagues and/or employers who suggest they seek help to help overcome gambling-related psychological, economic and legal problems (Pulford et al. 2009; Gainsbury et al. 2014). In some cases, shame and fear of stigma represent insurmountable barriers which prevent many gamblers from seeking help (Suurvali et al. 2009; Hodgins et al. 2012).

In an attempt to overcome some of these obstacles, new types of professional help have emerged, based on use of telephone and information technology (e.g., professional telephone helplines, online counseling). Indeed, several lines of evidence show that many high-risk gamblers prefer this type of approach when asking for help or beginning treatment due to the degree of perceived privacy and anonymity offered (Wood and Griffiths, 2007). Furthermore, such interventions – compared to traditional face-to-face methods – permit greater flexibility in time management as well as overcoming geographical isolation (Griffiths and Cooper 2003; Hodgins et al. 2013; Rodda and Lubman 2013). In particular, internet-based treatments may increase feelings of anonymity, encourage openness and honesty, and overcome practical barriers such as distance to treatment facilities, conflicts between treatment and other constraints on time including child care or paid work, cost of transportation to treatment facilities, and provision of treatment relevant to cultural or language needs (Sagoe et al. 2021).

Academic research on internet-based interventions used to address gambling harm have been published in several different countries, with particularly strong representation in Australia, New Zealand, UK, and Scandinavia (e.g., Molander et al. 2020; Rodda et al. 2019; Wood and Griffiths 2007). Cognitive behavioral therapy (CBT) appears to be the most common form of internet-based intervention used to treat high-risk gamblers and has been shown to be effective in reducing gambling harm scores and gambling behaviors more generally (Tolchard 2017). CBT typically involves monitoring of gambling behavior, psychoeducation, cognitive and behavioral strategies aiming to control behavior, learning problem-solving skills, coping strategies of dysphoric emotions, and relapse prevention (Raylu and Oei 2010). A wide range of interventions that have made use of internet resources included text-based interactions with counselors and peers, automated personalized and normative feedback on gambling behaviors, and interactive cognitive behavioral therapies (Van der Maas et al. 2019).

Given these benefits, telephone and online counselling and assistance services for gamblers have been introduced in several countries (Gainsbury and Blaszczynski 2011) such as Italy (where the present study was carried out). A recent epidemiological study confirmed that 3% of the Italian general population are high-risk gamblers (Italian National Institute of Health 2018) and the countrywide addiction services treat approximately 15,000 high-risk gamblers a year (Department of Anti-Drug Policies 2016). In October 2009, *Gambling Online Therapy* (GOT), managed by the Italian Federation of Workers of the Departments and Services Addiction (and known as FeDerSerD in Italy) was introduced, and is the first Italian national helpline dedicated to helping overcome gambling harm. The service provides free and anonymous professional counselling and web assistance (e-mail and chat) not only to gamblers, but also to those indirectly affected, such as relatives and friends. In August 2013, GOT introduced an additional program of internet-delivered cognitive behavior therapy (I-CBT) (Bastiani et al. 2015; Lucchini and Griffiths 2015; Lucchini et al. 2018).

I-CBT has proved to be a valuable complement to traditional cognitive behavioral therapies for the treatment of psychiatric disorders and other clinical problems (Hedman et al. 2012). A review by Merkouris et al. (2016) identified the available evidence regarding outcomes for gamblers following psychological treatment for gambling harm. Positive treatment outcome was associated with being male, being older aged, and not having gambling debt whereas there was no association with education level and income. However, there were several inconsistencies between Merkouris et al.'s findings and those identified by a previous systematic review of treatment outcomes from psychological treatment for gambling harm (Melville et al., 2007). More specifically, Melville et al. identified being older aged, having lower gambling debts, and having a longer duration of gambling behavior as potential predictors of treatment dropout, whereas Merkouris et al. suggested that being older aged and having no gambling debt were associated with positive treatment outcomes. In summarizing these findings, it appears that dropping out of treatment is associated with a having longer duration of gambling behavior, having a lack of

social support, being younger at age of gambling onset, and having lower gambling debt. Furthermore, being female, being younger aged, and not having a significant other are associated with a less positive response to these treatments (Carlbring et al. 2012).

Taking into account the aforementioned considerations and by using a mixed-methods approach, the present study: (i) describes the socio-economic and gambling characteristics of an internet-delivered therapy patients and identified outcome predictors; and (ii) analyzes the stories of high-risk gamblers who successfully completed the therapy, proposing a typology of such patients through their narratives.

Methods

Participants

The participants comprised a non-randomized consecutive sample. Of the 4,742 gamblers (83.4% males) who accessed GOT services between August 2013 and July 2020, the present study comprised 784 gamblers who began internet-delivered therapy and 177 gamblers (22.6%) who completed the entire treatment (84.7% males).

Data collection and instruments

Users are required to register on the GOT website, and anonymity and confidentiality are guaranteed throughout their treatment. Engagement in treatment is characterized by significant aspects that concern the motivational process (Gómez-Peña et al. 2012). Motivation appears to be a critical factor both for accessing and completing therapy. Generally, the decision to enter therapy is not impulsive, and results from an individual internal negotiation, sometimes confronted with a family member, and mainly related to negative externalities (e.g., large financial debts, family breakdowns, etc.).

Access to therapy is subject to an assessment of both the severity of the gambling disorder and the motivation for treatment. For the motivational assessment, a short test based on clinical experience (Miller and Rollnick 2014) identified four different profiles: low motivation and low perceived self-efficacy; low motivation but high perceived self-efficacy; high motivation but low perceived self-efficacy; high motivation and high perceived self-efficacy. Assessment of gambling disorder is based on the Problem Gambling Severity Index (PGSI) (Ferris and Wynne 2001), a nine-item screening tool used to assess the severity of gambling harm in the general population. The PGSI has a range of 0 to 27, describing different levels of problem gambling. A score of 0 indicates the individual does not have a problem (social gambling); a score of 1 and 2 indicates a low risk (low risk gambling); a score of 3 to 7 indicates a risk, although limited, of developing a problem (moderate risk gambling); and a score between 8 and 27 indicates problem gambling.

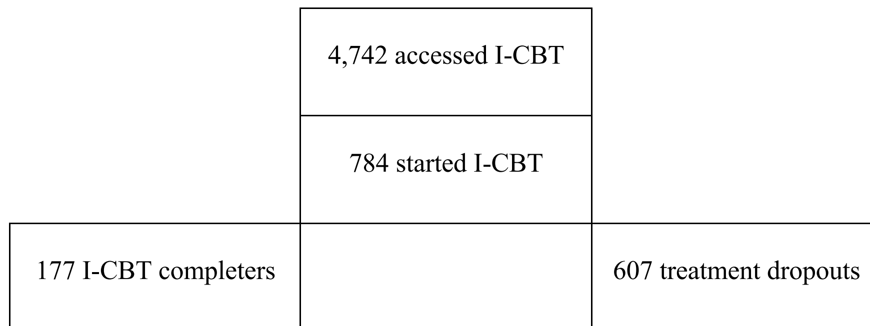
Program modules are visible in a private session accessed by the patient using a personal user ID and password, and are managed by therapists in agreement with the patient. Furthermore, patients must attend a weekly 30-minute telephone conversation with the assigned therapist. Patients completing the therapy continue to receive treatment for nine months, with two follow-ups (in the third and sixth months after completion). The others drop out after an average of four months. The GOT I-CBT is structured in five phases associated with nine related goals:

(1) Assessment;

(2) Functional analysis (first goal to identify risky situations; second goal to keep a weekly gambling diary; third goal to identify gambling-related factors);

(3) Craving[1] management (fourth goal to manage craving intensity; fifth goal to reformulate craving-related dysfunctional thoughts; sixth goal to evaluate craving-related rational thoughts);
(4) Resource management (seventh goal to get out of debt and/or manage personal resources independently);
(5) Relapse prevention (eighth goal to react to slips in gambling harm; ninth goal to recognize high-risk situations).
Finally, patients are asked to complete a customer satisfaction survey comprising 14 items (minimum score = 1; maximum score = 5) related to the structure (timing, working mode, contact with the therapist) and effectiveness of the treatment received and to therapist-patient relationship (Figure 1).

Figure 1. GOT internet-delivered cognitive behavior therapy: Completers and dropouts



During the therapy, information on the following variables was collected:

(a) Socio-economic status: gender, age, marital status, educational level, employment status, housing situation;
(b) Gambling behavior:
    (i) History of gambling (duration of gambling activity): less than one year, less than 10 years, 10 years or more;
    (ii) Awareness of problem gambling (duration of self-perception of problems related to gambling activity): less than one year, less than 10 years, 10 years or more;
    (iii) Types of games played: strategy-based games (poker, blackjack, horse race betting, sports betting, and other betting), non-strategy-based games (lottery, video lotteries and slot machines, pull tabs, scratch-cards, bingo and keno), both strategy-based and non-strategy-based games[2];
    (iv) Gambling setting: offline venue, online website;
    (v) Frequency of gambling: occasional (less than once per week), moderate (1-2 times per week), regular (up to 6 times or more per week);
    (vi) Monthly expenditure on gambling: amount of money spent monthly: < 1,000 euros; from 1,000 to 10,000 euros; > 10,000 euros;

[1] The desire for more of a substance or activity (e.g., drugs or gambling) consisting of a desire to experience the effects, as well as the desire to avoid the withdrawal aspects of abstinence.
[2] Non-strategy-based games involve little or no decision-making or skill, and gamblers cannot influence the outcome of the game; strategy-based games allow gamblers to attempt to use knowledge of the game to influence or predict the outcome.

(vii) Gambling debts: < 1,000 euros or no debts; from 1,000 to 10,000 euros; > 10,000 euros.

Data analysis

Descriptive analyses of the data were performed using STATA 13.0 (STATA Corp., TX, USA) and SPSS v.21.0 (IBM Corp., Armonk, NY, USA). A Cox model with the backward stepwise procedure was performed to evaluate the relationship between treatment completers (dependent variable) and the covariates assessed in the present study (independent variables).

The summary of each telephone interview and the therapist's evaluations on therapy evolution were recorded. Each therapist analyzed the clinical diary of each patient in charge from the first interview until the end of treatment (average: 25 telephone conversations lasting about 30 minutes) and follow-up at three and six months, when present. To analyze the gamblers' stories, each therapist compiled a qualitative report for each patient following a common model, including an evaluation of the motivational and psychological indicators collected in the initial phase compared with the evolution of therapy and patient compliance. More specifically, reports compiled by therapists for each patient were analyzed using qualitative content analysis, a flexible method for identifying, analyzing, and reporting themes within qualitative data. This approach seeks to identify themes and patterns of behavior and meaning in search of common elements, relationships, theoretical constructs or explanatory principles (Hussain and Griffiths 2009; Veltri 2019). Of the 177 gamblers who completed the treatment, 160 were included in the final analysis (134 males and 26 females). Seventeen patients were excluded from the analysis because they were being treated by therapists who were no longer working with the service at the time of the study.

Results

As noted above, motivational assessment identifies four different profiles. The proportion of participants in each profile were as follows: (i) low motivation and low perceived self-efficacy (0%; no service user matched this profile in the present study); (ii) low motivation but high perceived self-efficacy (1.5% of service users); (iii) high motivation but low perceived self-efficacy (47.3% of service users); and (iv) high motivation and high perceived self-efficacy (51.2% of service users). Users matching the first profile are automatically excluded from the therapy. The assessment of gambling disorder based on PGSI indicated that of the 4,742 gamblers who accessed the internet-delivered therapy 0.5% were social gamblers, 0.2% were low risk gamblers, 4.2% were at moderate risk gamblers, and 95.1% were problem gamblers.

Table 1 shows socio-economic status and gambling behavior of patients who entered the therapy. Based on the analysis, typical treatment patients were male (78.1%; mean age of the total sample = 45.1 years), had a medium-high level of education, were in full-time employment, lived with partner and children or with family of origin, had been gambling for one year or more, gambled on a daily basis, mainly offline, had debts, and preferred non-strategy-based games. Slips and relapses in gambling were reported by almost all patients. A total of 24 gamblers relapsed and returned in treatment, while seven relapsed after treatment had finished but did not return to therapy. The average duration of therapy for the total sample was more than six months.

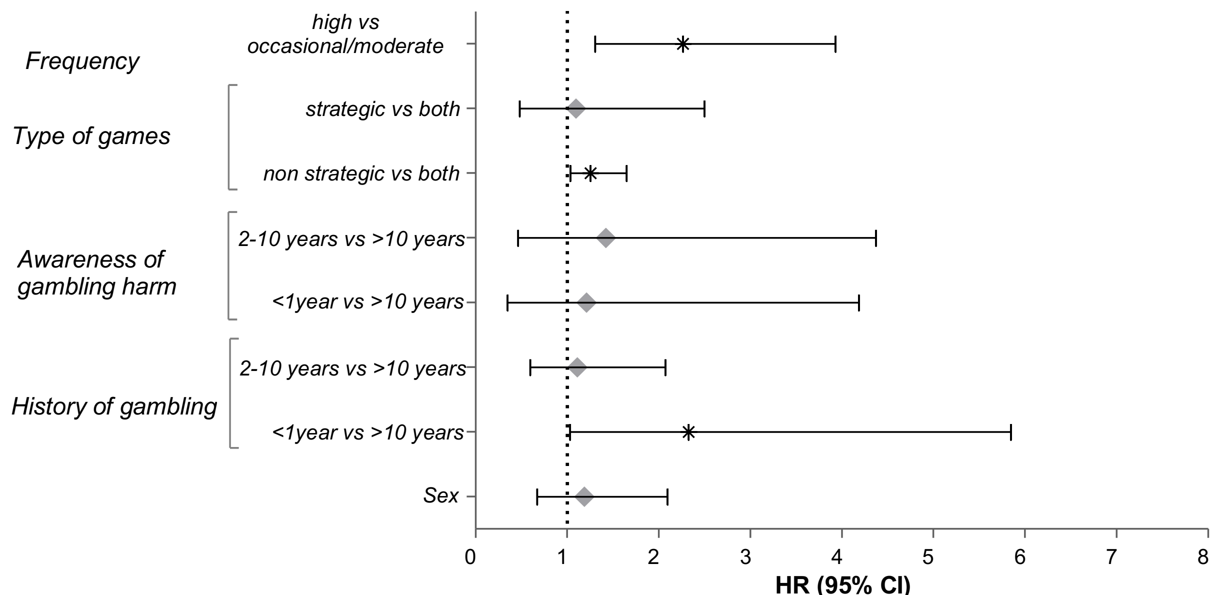
Table 1. Descriptive statistics: Socio-economic status and gambling behavior

Variables	Treatment patients

		% (n.)
Gender	M	78.1 (612)
	F	21.9 (172)
Mean Age	M (44) F (50)	45.3
Marital status	Married	27.9 (219)
	Unmarried	42.7 (335)
	Separated/divorced	29.4 (230)
Educational level	Middle school	20.4(160)
	High school	63.8 (500)
	University	15.8 (124)
Employment status	Unemployed	10.7 (84)
	Employed	89.3. (700)
Housing situation	Alone	24.2 (190)
	With partner or children	52.8 (414)
	With family of origin	23 (180)
History of gambling	Less than 1 year	4.5 (35)
	<10 years	45 (353)
	10 or more years	50.5 (396)
Awareness of gambling harm	Less than 1 year	27 (211)
	<10 years	56.3 (442)
	10 or more years	16.7 (131)
Type of game	Non-strategy-based games	62.8 (492)
	Strategy-based games	12.4 (97)
	Strategy and non-strategy-based games	26.8 (195)
Frequency of gambling	Occasional (less than once a week)	11(86)
	Moderate (1-2 times a week)	21.8 (171)
	Regular (up to 6 times a week)	67.2 (527)
Gambling debts	<1,000 euros or no debts	20.8(163)
	From 1,000 to 10,000 euros	29.8(234)
	>10,000 euros	49.4 (387)
Gambling setting	Offline venues	88.5 (694)
	Online websites	11.5 (90)
Monthly gambling expenditure	<1,000 euros	50.5 (396)
	From 1,000 to 10,000 euros	48.9 (383)
	>10,000 euros	0.6 (5)

Cox model analysis (Figure 2) showed that treatment dropouts were more likely to prefer non-strategy-based games (hazard ratio [HR] = 1.27), gamble more frequently (HR = 2.25), and to have begun gambling less than one year before entering treatment (HR = 2.35).

Figure 2. Cox model analysis



Qualitative analysis

To analyze the gamblers' stories, each therapist compiled a qualitative report for each patient following a common model, including an evaluation of the motivational and psychological indicators collected in the initial phase compared with the evolution of therapy and patient compliance. As all patients reported, until a good level of motivation to change their gambling habits is achieved, it is difficult to seek help from a professional. Intervention of family members or others was not always initiated by the gambler, and in about half of cases (n=81), they preferred not to involve a third person. Motivation to seek treatment appears to associated with a crisis (e.g., financial, legal, family) derived from gambling problems rather than a progressive recognition of the gambling disorder (Evans and Delfabbro 2005). In fact, when gamblers in treatment were asked to explain why they sought online help (i.e., preferring remote help rather than face-to-face), the responses were composite and varied, but almost all (n=169) mentioned economic problems. One gambler said:

> *"Initially I didn't want to ask for help, I didn't think to have a problem, then when I realized that it wasn't like that and I realized I needed help, I looked for it ... I had no financial resources and therefore I was looking for a free therapy. This service was suggested to me by a relative"* (Patient 101).

Implicit or explicit admissions by gamblers about shame and fear of social stigma (n=157) were typical. For instance:

"I was not aware of the existence of Addiction Services in the area or even knowing of their existence, I would reconfirm the choice to begin this therapy, also because if I had had to start therapy in person, I would have been ashamed. Doing it on the internet was not so tough" (Patient 19).

"I'm not hesitant to ask for help and doing it online was a little less tiring, at least at the beginning. I avoided Addiction Services because I didn't want to meet drug addicts" (Patient 70).

Moreover, the burden of gambling harm is typically increased by the addition of stigma and its impacts (Hing et al. 2016). Again, preference for online gambling due to the physical distance of local services was raised by the majority of gamblers (n=112). For example:

"Not sure that there was a specific Addiction Service close to me and since the self-help groups are distant and uncomfortable for my working hours, I chose an online service, more in line with my needs" (Patient 23).

Furthermore, such interventions – compared to traditional face-to-face methods – permit greater flexibility in time management as well as overcoming geographical isolation (Griffiths and Cooper 2003; Hodgins et al. 2013; Rodda and Lubman 2013). In addition to the fear of social stigma and poor knowledge of Addictions Services, comfort and greater flexibility were particularly valued by 86 patients who completed follow-up at three months. According to some gamblers (n=44), the importance of therapist's role lies in correcting their approach to the issue:

"At first, I thought I was carrying out therapy for my family but my doctor instead reminded me to do it especially for me" (Patient 142).

Others appreciated *"the opportunity of not remaining centered only on symptoms but also of exploring other problems (e.g., resources management, personality aspects)"* (Patient 112). Another said:

"It was useful to understand that changing gambling behavior would not be enough to deal with this addiction; initially I had the goal of becoming a social gambler - namely continue to gamble in control - then I realized it wasn't the right way. It was essential to have a continuous dialogue with a therapist which helped me to understand that at the root of this problem there are various triggering causes" (Patient 81).

It was also useful to examine the benefits that clients obtained from their gambling and to help generate alternative, functional strategies that provide similar benefits. While some participants indicated that they had not reached their initial goal of total abstinence, all reported that they felt more in control of their urges than they had prior to treatment. Some indicated that they had come to alter their expectations through the course of therapy (Dunn et al. 2012).

Gambling patient types

By reviewing the stories of the patients who completed therapy that emerged from the analysis of records regularly compiled by the therapists, it was possible to outline four different types of gamblers in treatment with respect to specific reference variables: (i) motivation, (ii) adherence to therapy (iii) whether they relapsed or not. These four patient types were labelled as ‘compliant’, ‘autonomous’, ‘erratic’, and ‘fragile’.

Type 1 – Compliant patients (n=66 of 160; 41.2%): These patients were highly motivated to change, adherent to therapy, and not relapsing into gambling. This type of patient had high motivation but low perceived self-efficacy, clearly recognized gambling harm they experienced, although they were not very confident in their skills to cope with it. These patients usually had a dysfunctional relationship with money and feelings of guilt for their way of gambling. They recognized pursuit of gratification as the main gambling trigger. From the beginning of therapy, this kind of patient adopted strategies to avoid gambling venues, managing their money, and rethinking their life by introducing new habits. The therapeutic relationship was compliant, collaborative, and based on trust and empathy, with good adherence to treatment (only two gamblers reported gambling relapses in out of 73 in this group [3%]). Patients showed commitment, autonomy and awareness in the use of therapeutic instruments, since they prompted questions (e.g., about values, interests and goals) that are often neglected in gamblers’ daily lives as well as pointing out the existence of alternatives to gambling. This type of patient, in addition to tackling gambling harm, was usually able to disclose their personal and relational traits, strengthening therapeutic alliance, involving family in the care pathway, and reaching positive outcomes (e.g., gambling abstinence, initiation of a face-to-face psychotherapy, well-being improvement, etc.).

Type 2 – Autonomous patients (n=47; 29.4%): These patients were highly motivated to change, adherent to therapy, but sometimes relapsed (8 out of 47 patients [17%]). This type of patient had high motivation but low perceived self-efficacy, with good cognitive resources, but in some cases, poor social skills and limited self-esteem, which were strengthened in the course of therapy as a fundamental step for abstaining from gambling. Usually, these patients – among whom an early perception of mastery over urge may facilitate temporary withdrawal from therapy – had already stopped gambling for a time period. However, they were worried about having lost control of money and/or having debts. Family members were unaware of the gambling harm due to the gambler’s shame in exposing themselves. Even when partners and family members were aware, these patients preferred to undertake therapy in complete autonomy. The therapeutic relationship was trusting, collaborative, and empathic. The patient immediately relied on the therapist, without difficulty in talking about themselves and their problem with gambling, demonstrating compliance with therapy and disclosing significant and complex existential issues often associated with emotional and relational frustrations. In this regard, the sharing of the therapeutic path with family members, when it happened, resulted in a perceived improvement in the quality of life and well-being. In fact, when relatives, friends or others were involved in activating protective measures (time and money management in particular), slips or relapses were less frequent. Social support was a facilitating factor for this type of patient., Also – similar to the other types of patients analyzed in this study – at the beginning of therapy, the majority of patients were afraid to tell anybody at all about their gambling problems. In this group, those who had shared their story with a friend and/or family member, reported that they were encouraged to attend or continue therapy sessions.

Type 3 – Erratic patients (n=24; 15.1%): These patients were highly motivated to change, poorly adherent to therapy, sometimes relapsing in gambling. This type of patient had high motivation and high perceived self-efficacy, proving they were able to reach therapeutic goals, despite the fact of having overestimated, at first, the role of willpower and self-control. Generally, they assumed a prudent attitude, paying more attention to therapists' suggestions and instructions. These patients were often binge gamblers and accumulated substantial debts. Self-destructive dynamics emerged, linked to the difficulty of coping with job-related stress and fulfilling family and professional commitments. Such critical issues often resulted in family breakdowns, in turn associated with the onset or worsening of gambling harm. The therapeutic relationship was empathic and based on trust, using the sessions with therapist as a confidential space where feelings of guilt and lived experiences – often depression – emerged. At first, this type of patient did not fully grasp the protective measures suggested by therapist (e.g., craving and money management, relapse prevention, etc.) and found it difficult to use therapeutic instruments, particularly those included in the assessment and functional analysis (often considered too complex). In particular, these patients reported finding their homework tasks difficult and time-consuming but then they usually proved to be flexible enough to comply with therapeutic goals and to be accompanied towards a path of change.

Type 4 – Fragile patients (n=23; 14.3%): These patients were highly motivated to change, poorly adherent to therapy, and had a higher propensity to relapse into gambling. This type of patient had high motivation and high perceived self-efficacy, with oscillating attitudes towards therapy, characterized by several reported relapses (10 out of 23 patients, 43.4%). These patients had an ambivalent relationship with gambling, considered, on the one hand, as a leisure activity to make money, but on the other hand, as a cause of relational and family problems. Usually, once engaged in the therapeutic path, they recognized erroneous perception of a gain associated with gambling, admitting that economic losses were the most important reasons pushing them into getting online therapy – sometimes undertaken after the failure of a treatment at Addiction Services. Even if these patients had generally a good cognitive level therapeutic relationship (demonstrated by accuracy and autonomy in the therapeutic instrument management), in these cases, they can be defined as not very trusting and discontinuous. However, in the medium term they established a greater collaboration with therapists, working on the re-elaboration of individual experience.

Discussion

The present study described the socio-economic and gambling profiles of high-risk gamblers who entered the GOT program, defining outcome predictors of an internet-delivered therapy for those experiencing gambling-related harm. Compared to treatment completers, Cox analysis showed that gamblers had a higher likelihood of being a treatment dropout if they preferred gambling on non-strategy-based games, gambled frequently, and started gambling in the past year.

Results related to gambling frequency are consistent with research associating high frequency gambling with gambling disorder (Hodgins et al. 2012; Cavalera et al. 2018). With respect to the association between non-strategy-based games and dropouts, it is acknowledged that structural characteristics of non-strategy-based games, and slot machines in particular, have the capacity to stimulate cognitive biases such as illusion of control, flexible attributions, representativeness, availability bias, illusory correlations and fixation on absolute frequency (Griffiths 1994; Meyer et al. 2011; Scalese et al. 2016).

With reference to gambling habits, Merkouris et al. (2016) reported that likely predictors of successful treatment outcome include being male, older aged, employed, having a lower severity of gambling symptoms, and lower levels of gambling

behavior. They also reported that history of gambling and gambling harm duration did not appear to be significantly associated with the treatment outcome. These results do not fully concur with the findings of the present study. These inconsistencies may be partially explained by several methodological issues. For instance, it may be difficult to generalize the findings obtained from patients recruited via advertisements to patients seeking treatment in real-life settings (Fink et al., 2012), as in the case of the GOT I-CBT in the present study.

Moreover, individuals with a recent onset of gambling and an equally recent development of gambling harm (less than one year) may have not consolidated enough motivation for behavioral change. Motivation is often triggered by gambling-related financial difficulties that have worsened over time (Ledgerwood et al. 2013). Therefore, some gamblers may not be sufficiently motivated when approaching a treatment that – while freely available online – requires an ongoing commitment. The present study also analyzed patient characteristics that are important for a successful online therapy, considering that, for many gamblers, therapy represents an opportunity to make a radical change in perceptions, habits, and lifestyles.

On a general level, a lasting and solid therapeutic relationship is a source of gratification for patients because it strengthens and confirms the gambler's commitment to change. Consequently, therapy becomes a space for reflection on gambling and the existential aspects related to it (e.g., family life, work commitments, time and money management, etc.). These are situations that gamblers are often unable to appropriately assess and manage without external support, that may also be useful for defining strategies and alternative behavior to gambling. Even the instruments (tests and scales) that are part of the therapeutic model, initially criticized by many gamblers for their complexity, actually contributed to a deconstructive and reconstructive effort of the gambler's daily experience because they stimulated questions (e.g., about values, interests and personal or professional goals) that are often overlooked in routine showing the existence of alternatives to gambling. These emerging *narratives of reduction and change* (Reith and Debbie 2013) articulated a regaining of control over time and money and a rebuilding of the self and relationships. Telling and retelling their stories and sharing their narratives with others represent for many gamblers the crucial point of recovery (Nuske and Hing 2013).

The sense of agency and autonomy expressed in gamblers' narratives can be seen as part of a process of biographical reconstruction, in which individuals regain control of time, their selves, and a sense of their future, questioning the definition of excessive gambling just in medicalized terms as pathology or disorder (Cosgrave 2020). This means, following the Goffmanian conception, that agency and character could have role in the process of change (Goffman 1967). The evolution of material and social circumstances in which gamblers act emerged as important in the narratives of reduction and change. In fact, without substantial differences between all the different types analyzed, the gamblers interviewed spoke of life events that stimulated their gambling (trauma and stress), of circumstances that prompted them to seek help (indebtedness and personal, family and social problems) and, also as a result of reflections related to the therapeutic course undertaken, of situations (changes in personal and work life) that prompted them to reduce or stop gambling. The totality of those interviewed highlighted the relevance of the availability (or not) of family and friends for perceived social support, in terms of both practical and emotional encouragement, particularly when they had consciously decided to reduce their gambling taking action to do that. In fact, as it is particularly evident from the analysis of *compliant patients* (*Type 1*) and *autonomous patients* (*Type 2*), when relatives, friends or others are involved in activating protective measures, slips or relapses are less frequent.

In this respect, *compliant patients* have traits in common with *patients with cooperative psychological functioning* identified by Montourcy et al. (2018), whose awareness of the negative impacts on their lives represent a therapeutic lever and may lead them to attempt to solve their problems, while *autonomous patients* seem to be akin to *patients with resilient*

psychological functioning, characterized by good coping skills. Lastly, still referring to the aforementioned study mentioned, *erratic* and *fragile patients* exhibit similarities with *patients with complex psychological functioning*, deeply affected in various domains of their life, and whose compliance with therapy is oscillating (Blaszczynski and Nower 2002).

Limitations

The present study is subject to limitations. In particular, the sample was relatively small and a self-selecting sample, including just recovering high-risk gamblers who had sought professional help. Moreover, the study, in particular the qualitative data, relied on retrospective accounts of therapists (i.e., reports compiled by therapists for each patient) which may suffer from recall and interpretation biases. Therefore, it is acknowledged that the present study provides only a beginning to understanding new ways to analyze help-seeking behavior and recovery from gambling harm.

Conclusion

There is no consensus on how to best define recovery in gambling harm and this minimizes clinicians' abilities to apply optimal treatment goals and contributes to inconsistency in the use of outcome variables to evaluate interventions. Current understanding of recovery is mainly based on professional opinion and theoretical models of gambling disorder and it is largely perceived as a continuous process that encompasses periods of improvement and decline, highlighting the importance of developing insight into the psychological and environmental processes that contribute to gambling harm (Pickering et al. 2020). Moreover, the burden of gambling harm is typically increased by the addition of stigma and its impacts. This stigma is created and maintained by a lack of public understanding about problem gambling and its causes, and internalization of self-stigmatizing beliefs, leading to delayed help-seeking, anxiety about attending treatment, concerns about counsellor attitudes, and fear of relapse (Hing et al. 2016).

In a mixed-methods study such as this, it is important to recognize that different research approaches produce different types of knowledge. The present study was an attempt to situate gambling socially, broadening the focus beyond the lone individual and reconnecting gamblers with their wider social networks. Such an approach shows how change is lived and experienced by individuals. In particular, narratives of reduction and change among gamblers entering into online therapy elicits a view of behavior that is extremely dynamic, continually moving away from, as well as towards, problems with gambling in ways that are multidirectional and fluid.

On the one hand, this research reaffirms the increasing role of motivation to enhance the efficacy of cognitive-behavior therapies for gambling harm (Gómez-Peña et al. 2012). On the other hand, emerging evidence confirms that establishing trust between patients and therapists restores the patient's self-esteem, enhances stigma coping skills, fosters a belief that recovery is possible, harnesses support from significant others and prepares patients for relapse and may be relevant in improving patients' treatment adherence and recovery.

In this regard, as shown in the proposed typology of patients, recovery from gambling harm means building a meaningful life beyond gambling, which involves engagement in alternative activities and fostering strong social relationships, including stabilization of personal finances and achieving general psychological health and wellbeing. In describing this process, the context of individual experience – declined in terms of personal characteristics and socio-economic conditions – is crucial since similar situations can have both positive and negative impacts on gambling behavior, a phenomenon multilayered and

socially situated with a number of interrelated themes running through patients' narratives of reduction and change (Reith and Debbie 2013).

Therefore, reflecting on the complex intertwining of individual agency, structural conditions, and the role of patients' narratives within the recovery process, the underlying contribution of this study could be the development of effective strategies that help inpatient retention in treatment and better treatment outcome, as well as a clearer understanding of the characteristics of high-risk gamblers who might benefit from internet-delivered therapy. In view of this and from a public health perspective, further studies are needed to assess whether, and how, such a therapeutic approach could be permanently integrated into the treatment offer of the national health services, especially at a time of widespread budgetary difficulties.

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