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Problem gambling and non-help-seeking: Perspectives of intimate partners, gambling venue staff, and gamblers

By

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ABSTRACT

Despite substantial harms inflicted on individuals and their families caused by problem gambling and a range of available treatments, most individuals in need do not seek formal assistance. Given their contact with people with gambling problems who are not actively seeking help, both gambling venue staff and families have been indicated as potential opportunities to facilitate help-seeking. To understand these opportunities, this thesis examines the experiences of venue staff and intimate partners of individuals with gambling problems who are not seeking help, along with individuals with lived experience of problem gambling.

Five studies: three literature reviews and two qualitative studies, were conducted. The first literature review comprised peer-reviewed and grey literature and examined the role of gambling venue staff in gambling venues that operate electronic gaming machines, in facilitating harm reduction and help-seeking. The second literature review systematically examined peer-reviewed evidence concerning the impact of gambling-related harm on concerned significant others.

Qualitative study 1 involved in-depth interviews with 15 participants and examined the lived experiences of partners living with a person with a gambling problem who was not seeking help. Qualitative study 2 examined the experiences of gambling venue staff and gamblers concerning the identification and engagement of individuals with gambling problems in gambling venues and involved three focus groups and nine in-depth interviews.

Role conflict and ambiguity emerged as dominant themes across the two qualitative studies. As such, a third literature review was performed to examine peer-reviewed sources regarding the current knowledge and theories concerning role conflict and role ambiguity

more broadly and to consider how this literature related to and informed the findings of the two qualitative studies.

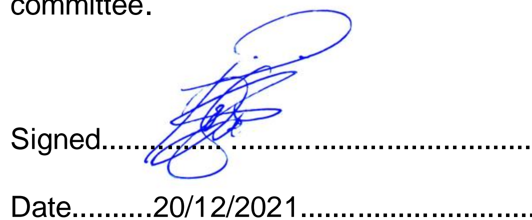
The results of this thesis can be summarised in four broad findings. First, managing the effects of a person's gambling problem can be hampered by role conflict: a perceived conflict between venue staff promoting harm reduction while encouraging gambling impaired effected engagement between staff and gamblers around help-seeking; and a reorganisation of roles within intimate couples to manage the effects of problem gambling added further strain to the relationship. Second, engaging non-help-seeking individuals with gambling problems about their gambling is complicated by perceived stigma. Third, detecting problem gambling behaviour reliably is difficult. While venue staff felt confident that they could identify visible problem gambling behaviours, they were less confident in identifying a patron as having a gambling problem, and intimate partners described difficulty in detecting more covert gambling behaviours. Fourth, a disproportionate emphasis on individual accountability for responsible gambling is not working. The findings of this research have shown that waiting for people to actively seek help or exhibit signs of gambling-related harm, is too late. This thesis has indicated a need for a shift away from a responsible gambling paradigm of individualism to a more holistic multifaceted approach with a focus much earlier in the help-seeking process; one that better engages with and supports families and gambling venue staff to provide support to the gambler to recognise and seek help earlier.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

The two qualitative studies are multi-authored chapters on which Ben Riley was the primary author and completed the majority of the work. The development and management of the studies, data collection and analysis, publication writing, and revisions were led by Ben Riley. Co-authors assisted with study development and analysis, as well as publication preparation, as referenced.

The data collected for the first qualitative study presented in Chapter 6 was collected as part of a larger study led by Ben Riley for the South Australian Gambling Advisory Committee inquiry into the referral process from gaming venues to gambling help services. Focused questions were included in the larger study to inform the research presented in this thesis. All research procedures reported in this thesis were approved by a relevant ethics committee.



Signed...

Date..........20/12/2021.............................

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LIST OF PUBLICATIONS AND CONFERENCE ABSTRACTS ARISING FROM THIS THESIS

Publications

Riley, B. J., Harvey, P., Crisp, B. R., Battersby, M., & Lawn, S. (2021). Gambling-related harm as reported by concerned significant others: A systematic review and meta-synthesis of empirical studies. *Journal of Family Studies, 27*(1), 112–130. (Journal impact factor 1.96)

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Riley, B. J., Orlowski, S., Smith, D., Baigent, M., Battersby, M., & Lawn, S. (2018). Understanding the business versus care paradox in gambling venues: a qualitative study of the perspectives from gamblers, venue staff and counsellors. *Harm Reduction Journal, 15*(1), 49–49. (Journal impact factor 4.36)

Conference presentations and posters

**Denotes presenting author*

Riley, B. J*., Harvey, P., Crisp, B. R., Battersby, M., & Lawn, S. (2019, November 7-9). *Gambling-related harm as reported by concerned significant others: A systematic review and meta-synthesis of empirical studies.* [Paper presentation]. ASW Conference: Challenging inequality: Working together for a just society, Adelaide, South Australia.

Riley, B. J*., Orlowski, S., Smith, D., Battersby, M., Baigent., & Lawn, S. (2018, February 12-14). *Business versus care in gambling venues: Understanding the paradox* [Poster presentation]. International Gambling Conference: Flipping the iceberg on gambling harm, mental health and co-existing issues, Auckland, New Zealand.

ABBREVIATIONS

CBT	Cognitive behavioural therapy
CRA	Community Reinforcement Approach
CRAFT	Community Reinforcement and Family Training
EGMs	Electronic gambling machines
ATM	Automatic teller machine
GREO	Gambling Research Exchange Ontario

CHAPTER 1. INTRODUCTION

This chapter outlines the origins of this thesis (section 1.1), context (section 1.2) of the research, and its purposes (section 1.3). Section 1.4 outlines the methods used to address the research aims, and section 1.5 describes the significance and scope of this research. Finally, section 1.6 includes an outline of the remaining chapters of the thesis.

1.1. Origins of this thesis

My training is in social work and Master's of cognitive behavioural therapy (CBT). During my social work degree, I took an elective topic on addictions delivered by Professor James Barber at Flinders University School of Social Work. Professor Barber pointed out that the majority of people with addiction problems do not seek help and when they do after many years considerable harm has been caused to themselves and their families. He proposed that social workers were well placed to consider approaches at a family level that might engage individuals with addictions who were not contemplating change, in help seeking. He described his interest at that time in working with alcohol addiction in the context where the addicted individual absolutely refused to seek help. He believed there was opportunity to work with families by using essentially, a contingency management approach to motivate the treatment refuser into treatment, while empowering the family member/s and enhancing their wellbeing. He and colleagues Beth Crisp and Robyn Gilbertson were in process of developing and evaluating a unilateral intervention for partners of treatment refusing heavy drinkers. I followed this work with interest (Barber & Gilbertson, 1997a, 1997b; Barber & Crisp, 1995; Barber & Gilbertson, 1996).

Since that time, I have worked in public mental health for a little over 20 years. I spent the first decade of my career working in inpatient and community settings of the public mental health service. After completing my training in CBT, I began working with the Flinders

Intensive Gambling Therapy Service (now the Statewide Gambling Therapy Service within Flinders Psychological Therapy Services), which was my introduction to problem gambling. Prior to this I had little knowledge or understanding of problem gambling. During my work with community mental health I can recall one maybe two occasions where gambling issues were mentioned, despite disordered gambling being overrepresented among clients of community mental health services (Manning et al., 2017; Manning et al., 2020).

For the past decade I have worked almost exclusively with individuals and their families affected by problem gambling and am still astounded by harms caused by this addiction. I have worked with individuals struggling with problem gambling, couples, parents of adult children with gambling problems, and adult children with parents with gambling problems. I have heard the stories of family breakdown, suicide, and financial ruin. I have learned that problem gambling does not discriminate. Among the many gamblers I have treated have been highly qualified professionals, tertiary students, unemployed individuals, retirees, pensioners, and gaming room managers and gambling industry staff.

The good news is that some individuals with gambling problems have effectively been treated with CBT (Gooding & Tarrier, 2009; Petry et al., 2017). I have seen firsthand the effectiveness of treatment and how affected individuals can recover and rebuild their lives. Sadly, however, too many clients I have treated, struggled with their addiction for many years before seeking help and had thus endured significant financial and psychosocial harms by the time they presented for help. These clinical observations are consistent with the literature (Pulford et al., 2009; Tavares et al., 2002). Furthermore, while it can take many years before some individuals seek help, only a small percentage of addicted gamblers actually seek professional treatment (Dąbrowska et al., 2017; Delfabbro et al., 2007; Loy et al., 2018; Slutske et al., 2009).

As I became more involved in problem gambling research, predominantly focused on the improvement and evaluations of CBT treatments (e.g., Riley, 2014; Riley et al., 2011; Riley, 2015), I found it increasingly more difficult to ignore the fact that so few afflicted individuals seek treatment. I often reflected on Professor Barber's comments from two decades earlier. What does it matter if we have effective addiction treatments available when so few people access them? I revisited the work that he and his colleagues conducted in the mid to late 1990's with families/partners of treatment refusing heavy drinkers (Barber & Gilbertson, 1997a, 1997b; Barber & Crisp, 1995; Barber & Gilbertson, 1996), and wondered if these approaches could be applied to problem gambling. At the time I first considered this, there had been two attempts at applying a unilateral intervention based on contingency management in the context of non-treatment seeking gamblers with problems (Hodgins, Toneatto, et al., 2007; Makarchuk et al., 2002). Makarchuk et al. (2002) and Hodgins et al. (2007) adapted a Community Reinforcement and Family Training (CRAFT) intervention, which was originally developed for use with alcohol disorders. The intervention was essentially aimed at motivating the treatment refusing gambler to engage in treatment. It did not achieve this aim.

On consideration of the initial Makarchuk et al. (2002) and Hodgins et al. (2007) work, and discussion with my principal supervisor Professor Sharon Lawn, it became apparent to me that the leap from using an intervention designed for use with partners of non-help-seeking individuals with substance use problems, to those of individuals with gambling problems, was too great. We cannot assume that the experiences of partners of treatment refusing substance users are the same as those living with non-help-seeking individuals with gambling problems. An initial search of the literature at that time (2016), indicated that there was little research on families of gamblers with problems who refused to seek treatment, to guide the adaption or development of strategies to encourage such gamblers to engage with help. Further, a preliminary search of the literature on barriers to problem gambling help-seeking appeared to focus predominately on gamblers' perspectives, and on those gamblers

who had sought help, ignoring the wider context in which non-help-seeking exists, such as gambling venues, families, and the wider community. Therefore, the focus of the current research was to examine the issue of problem gambling non-help-seeking, from perspectives beyond those of gamblers, to gambling venue staff and intimate partners.

1.2. The context of this thesis

1.2.1. The problem with gambling

Gambling is a popular activity in many countries. National gambling prevalence surveys conducted worldwide conclude that most individuals have gambled at some point during their lives (Calado & Griffiths, 2016). Australians are particularly fond of gambling with Australia boasting the largest gambling participation rate (Productivity Commission, 2010), gambling expenditure (Armstong & Carroll, 2007) and among the largest number of electronic gaming machines (EGMs) per capita in the world (Ziolkowski, 2018). In Australia, total gambling expenditure (losses) increased by 5% from $23.694 billion in 2016–2017 to $24.887 billion in 2017–2018 (Queensland Government Statistician's Office, 2019). While most gamblers do not develop clinical problems, for those who do, the consequences can be catastrophic.

Researchers have found it useful to categorise problem gambling into levels to distinguish between individuals who have severe gambling problems and those with moderate problems (Shaffer et al., 1999a). Level 1 represents individuals who do not have a gambling problem. This includes both gamblers without problems and non-gamblers. Level 2 represents subclinical levels of problem gambling which includes gamblers termed “problem gamblers”, “potential pathological” and “at-risk” gamblers. Level 3 represents the most severe level of problem gambling, “pathological” (Shaffer et al., 1999a) or gambling disorder (American Psychiatric Association, 2013). In general, the term problem gambling refers to gamblers

with moderate or severe problems. Several measurement instruments have been developed and used to measure population prevalence of problem gambling, and while there are some correlation and classification differences between measures with regards to measuring prevalence in populations, their primary value lies in providing comparisons over time (Caler et al., 2016).

Problem gambling rates worldwide range between 0.12–5.8% (past 12 months) and 0.7–6.5% (lifetime), the variability being due in part to different methodological procedures, instruments, cut-offs, and time frames (Calado & Griffiths, 2016). In general, the evidence suggests that problem gambling rates began increasing in North America and Australia inthe late 1980s to early 1990s, coinciding with the expansion of legalised gambling opportunities, particularly casinos and EGMs (Williams et al., 2012). Between 1980 and 2006 Australia experienced a doubling in the amount of disposable household income spent on gambling, the majority of this increaseoccurring in the mid-1990s following the introduction of EGMs into hotels outside of major casinos (Armstrong & Carroll, 2007).

Despite a steady increase in the availability of gambling in most jurisdictions over the past three decades, worldwide there has been a general downward trend in problem gambling rates since around 2000, with rates now similar to where they were in the late 1980s (Williams et al., 2012). That being said, gamblers with gambling problems contribute significantly and disproportionately to gambling expenditure. Studies report between 15-50% of revenue is derived from those with gambling problems (GREO, 2019) and a reported 40% of all losses from EGMs are contributed by people with gambling problems (Productivity Commission, 2010).

Problem gambling is associated with significantly harmful personal and social impacts such as occupational loss, family breakdown and suicide (Productivity Commission, 2010). For every individual with a gambling problem, five to 10 others such as partners and children are

also adversely affected (Goodwin et al., 2017; Productivity Commission, 2010), suggesting up to five million Australians (or up to one in five) experience the emotional, social, and financial stress caused by problem gambling. Furthermore, there is growing attention to the harms that arise from heavy gamblers who do not meet criteria for a gambling disorder (Abbott, 2020; Raisamo, 2018). Interest in this group has arisen because, whilst the harms experienced by low-risk gamblers may be less severe than high risk gamblers, there are a greater number of low-risk gamblers, hence the burden of harms is greater.

1.2.2. The problem with problem gambling treatments

The problem with problem gambling treatments, is that despite the prevalence of and harms caused by the addiction, and available treatments, the rate of help-seeking is exceptionally low: studies report between only three to 15% of individuals with gambling problems seek formal help (Productivity Commission, 2010; Volberg, 1997). Loy et al. (2018) conducted a review of help-seeking prevalence among people with gambling problems and concluded that the proportion of gamblers seeking help was fewer than 10% across studies. In contrast, Rodda et al. (2018) has suggested that help-seeking rates for people with gambling problems are much higher when taking into account a broader array of help-seeking behaviours, such as telephone helplines, online communications (emailing or chatting to an online counsellor), and self-directed options (e.g., reading information online or speaking to family or friends). A higher reported rate of help-seeking was similarly found by Riley et al. (2018) among incarcerated individual with gambling problems, although significantly lower rates were reported by Australian Indigenous respondents. Riley et al. (2018) suggested that the overall reported help-seeking rate of 25% found in their study was likely because the term “help-seeking”, as used in their survey, referred to any type of help, not only professional treatment.

While the rate of individuals with gambling problems seeking any kind of help for problem gambling across the lifetime, including self-directed help, was high in Rodda et al.'s (2018) study, the researchers found that the majority of respondents had not accessed face-to-face help with a professional. Importantly, evidence indicates that face-to-face treatments appear to be more effective for gambling disorder than self-guided treatments. Goslar et al. (2017) conducted a meta-analysis examining the efficacy of face-to-face versus self-guided treatments for disordered gambling, and concluded face-to-face treatments yielded significantly higher effect sizes. Furthermore, the sample of convenience used by Rodda et al. (2018) comprised gamblers accessing a problem gambling telephone helpline, and therefore may not have been representative of the broader population of gamblers experiencing problems; a limitation which was acknowledged by the authors.

Overall, help-seeking among individuals with gambling problems, particularly professional face-to-face help, appears to be extremely low. Delfabbro (2011) reported that only one in 10 people with gambling problems over a 12-month period sought formal help. In a study by Slutske (2009) only seven to 12% of gamblers reported they had ever sought formal treatment or attended meetings of Gamblers Anonymous for their gambling problem. Furthermore, formal help-seeking is often a last resort after experiencing significant negative consequences such as legal proceedings, family break up, job loss or psychological breakdown (Evans & Delfabbro, 2005; Productivity Commission, 2010). Hence, there is growing interest in whether gambling help services can be better targeted to gamblers before they reach a point of crisis (Delfabbro, King, et al., 2012).

Much of the research into problem gambling help-seeking, has investigated the issue from the perspective of gamblers. This is a logical place to begin, and studies both qualitative and quantitative, point to stigma as an important attributing factor to non-help-seeking and an assumption that gamblers know how to and are able to access professional help. However, the issue of help-seeking does not exist in isolation, that is, it is not an issue that sits only

with the gambler. While there is growing criticism of examining gambling problems from a largely individualistic perspective (Abbott, 2020; Hancock & Smith, 2017a, 2017b), responsible gambling frameworks continue to place an emphasis on individual responsibility (Shaffer et al., 2020; Shaffer & Ladouceur, 2021). There are, however, multiple factors that have the potential to influence help-seeking other than the level of the individual gambler, such as political (e.g., responsible gambling legislation), family (e.g., how do families experience and respond when living with a non-help-seeking person with a gambling problem?) and at the level of the gambling venue (e.g., responsible gambling initiatives and gambling venue staff). Whilst few seek professional treatment, people with gambling problems often turn to family members or friends for informal help (Hing, Tiyce, et al., 2013) highlighting the need to better understand this private world. In this thesis, it is argued that to understand the issue of non-help-seeking among people with gambling problems, in addition to the level of the individual gambler, it is necessary to understand the wider context in which help-seeking, or lack of help-seeking, exists. One way of achieving this is to examine the perspectives of other related groups.

1.2.3. The hidden world of non-help-seeking individuals with gambling problems

Families

Examining the hidden world of people with a gambling addiction before they acknowledge they have a problem or seek help has a number of discernible challenges. The most obvious challenge is that gamblers who refuse to acknowledge they have a problem are unlikely to respond to participant recruitment opportunities provided by problem gambling researchers. Given individuals with gambling problems adversely affect up to 10 others close to them, such as partners and children (Goodwin et al., 2017; Productivity Commission, 2010) examining problem gambling from the perspective of families may provide a valuable insight into the pre-help-seeking world.

There is some evidence that families may provide a pathway to assisting gamblers with problems to engage in treatment. Pulford et al. (2009) compared treatment-seeking and non-treatment seeking gamblers with gambling problems. Non-treatment-seekers were more likely thank treatment seekers to report family pressures and relationship problems as potential motivators to seek help, supporting the idea that families may be an important potential pathway to encouraging help-seeking. The importance of understanding the non-help-seeking world through the experiences of families is highlighted in a review by Clark et al. (2007) that points out that families are thought to have a significant influence on the gamblers' acknowledgement of their problem, and their decision to seek help, yet there is limited research directly focusing on their families.

Leiseur and Rothschild (1989) examined children of parents with gambling problems and, although they did not state whether or not the gambling parents were receiving treatment, the authors did distinguish between gamblers who acknowledged their problem and those who did not. They found children of parents where the parent acknowledged their problem, scored significantly better across all psychological measures, such as feeling happier, more secure, and less suicidal.

There have been several studies concerning families of people with gambling problems; however, the majority of these studies have involved families of gamblers who were receiving treatment (Dowling et al., 2009; Ferland et al., 2008; Lorenz & Yaffee, 1988; Mazzoleni et al., 2009; Vachon et al., 2004; Wurtzburg & Tan, 2011), or the authors did not state whether or not the gambler concerned was receiving help (Dickson-Swift et al., 2005; Holdsworth et al., 2013; Patford, 2007a). In a qualitative study of 23 female partners of individuals with gambling problems, Patford (2009) took care not to rely on a clinical population; however, they did not state whether or not the gamblers were receiving treatment or actively seeking help. Even less is known about the experiences of partners of

non-help-seeking individuals with gambling problems, even though partners are a uniquely situated grouping with close and intimate emotional and tangible connections with the gambling individual within the family network.

Venue staff

Given their regular contact with frequent gamblers, employees in gambling venues are considered to play an important role in reducing harm caused by excessive gambling and encouraging help-seeking (Allcock et al., 2002). Further, venue staff are among the first point of contact for individuals looking for help with gambling problems, as patrons develop rapport with the staff and are likely to view them as trustworthy (Productivity Commission, 2010). As such, an emphasis on venue staff to play an active role in interacting with people with potential gambling problems, is a common element of many responsible gambling codes of practice (Delfabbro et al., 2007; Fiedler et al., 2020). Gainsbury, Hing et al. (2014) examined barriers and motivators for problem gambling treatment and found concerns by the venue of the patrons' level of gambling were an important motivating factor among gamblers, although gamblers were largely unaware that they could seek assistance from venues.

Given the general reluctance of individuals with gambling problems to seek help (Delfabbro et al., 2007; Productivity Commission, 2010; Volberg, 1997), and gamblers' reported low levels of awareness of gambling help services (Hing & Nuske, 2012a), frontline gambling venue staff may provide an important opportunity to provide information about gambling help, encourage patrons of concern to seek treatment, and to facilitate referrals (Hing & Nuske, 2012a).

1.3. Purpose

The purpose of this research is to examine the hidden world of non-help-seeking people with gambling problems, by, in addition to examining the experiences of gamblers, conducting an inquiry into the experiences of gambling venue staff and partners of non-help-seeking individuals with gambling problems. The overall research question that serves as a guide to this research is:

What are the experiences and strategies/behaviours/responses of gambling venue staff and intimate partners of non-help-seeking individuals with gambling problems?

It is anticipated that through an examination of the lived experiences and perspectives of gambling venue staff and people living with a non-help-seeking partner with a gambling problem, insights will emerge which may provide opportunities for the encouragement of help-seeking and harm minimisation in these contexts, and better inform policy, and clinical practice and health messaging, concerning gambling-related harm minimisation, early intervention, and prevention.

1.4. Methodology

Given that the aim of this research is to examine phenomena largely unexplored, a qualitative methodology is used. Drawing on a Heideggerian philosophical perspective, this thesis uses a hermeneutical interpretive phenomenological approach, to facilitate an examination and understanding of the participants' lived experience. To achieve the aims of this research, a series of five studies will be presented. First, two literature reviews and two qualitative studies will be presented (Chapters 3 through 6). Following this, a third literature review will be presented (Chapter 7) which was undertaken to gain a deeper understanding of some of the key findings across the two qualitative studies.

1.5. Aims

This body of research aims to reach in-depth understandings of how gambling venue staff and partners of non-help-seeking individuals with gambling problems experience the behaviours of people with gambling problems, and their attempts to encourage gamblers to seek help. The research objectives are:

1. Examine the experiences and responses to people with gambling problems by gambling venue staff
2. Examine the experiences and responses to venue staff offers of help by gamblers
3. Examine the experiences and responses to people with gambling problems by intimate partners
4. Integrate the findings of objectives1 to 3 to make recommendations regarding the practices and strategies of gambling venue staff and intimate partners of people with gambling problems to encourage the gambler to seek help or minimise harm arising from their gambling.

The research presented in this thesis has the potential to significantly impact on the practice and training for gambling venue staff, potentially creating a safer environment for both gamblers and staff. Further, this thesis has the potential to significantly impact on how problem gambling treatment services involve the gambler's partner, and consequent outcomes for both gamblers and their partners' wellbeing.

1.6. Chapter outlines

This thesis is presented in 9 chapters. Chapter 2 reviews literature concerning non-help-seeking among individuals with gambling problems. This is followed by a discussion of the opportunities that families may provide in influencing help-seeking, along with a narrative review of known barriers to treatment for problem gambling. Given low help-seeking rates

among gamblers with problems it was deemed important to review the knowledge pertaining to treatment barriers. The results of the narrative review are summarised across four dominant categories. Chapter 3 presents a systematic review of gambling-related harms for significant others. This systematic review comprises a comprehensive review of empirical studies that have collected data from gamblers' significant others, from inception, along with identified gaps in the literature. A version of this chapter has been published (Riley et al., 2021) (Appendix 14).

In Chapter 4, a comprehensive review of the role of land-based gambling venue employees in facilitating problem gambling harm reduction and help-seeking is presented. The review includes both peer-reviewed and grey literature and is focused on venue staff of establishments that operate EGMs. Chapter 5 establishes the research paradigm for the two qualitative studies and provides a rationale for the use of interpretivism. A discussion of Heidegger's hermeneutic phenomenology follows, including the Heideggerian concept of time, and the importance of interpreting human experience in the context of the temporal frames - past, present, and future.

The first qualitative study is presented in Chapter 6 and examines the experiences and perceptions of problem gambling identification and referral for treatment, in gaming venues. Data were drawn from three focus groups and nine in-depth interviews, with participants comprising 22 gamblers and 10 gambling venue staff. A version of this study has been published (Riley, et al., 2018) (Appendix 15). Chapter 7 presents the second of the two qualitative studies: the lived experiences of individuals in a relationship with a non-help-seeking gambler with a problem. This study draws on data drawn from 15 in-depth interviews of individuals living with a partner who has a gambling problem and is not seeking help. A version of this chapter has been published (Riley et al., 2020) (Appendix 16).

A dominant theme that emerged and was shared across both qualitative studies concerned disrupted roles: role conflict and role ambiguity. Chapter 8 presents an umbrella review of literature reviews on role conflict and role ambiguity. The first purpose of Chapter 8 is to review the body of literature concerning role conflict and role ambiguity. The second purpose of Chapter 8 is to contextualise the findings of the umbrella review with the outcomes of the current research, that is, to examine how the phenomena - role conflict and role ambiguity - create difficulties for those who interact with affected gamblers; specifically, venue staff, and intimate partners.

To conclude the thesis, Chapter 9 presents a discussion of the key findings and their relationship to the existing literature. Limitations of this research are then acknowledged, ahead of a discussion of the policy, practice, and future research implications of this thesis.

1.7. A note on terminology

Several terms have been used to refer to individuals with gambling problems: “problem gambler”, “disordered gambler”, “compulsive gambler”, and “pathological gambler”. The term “problem gambler” has been perhaps the most widely used term across the literature to date. My views on the use of this term have shifted during the course of this thesis. I have closely examined issues around stigma associated with gambling problems, gambling-related harms and affected others, and approaches used by industry to address gambling harm. It has become clear to me, along with a growing number of researchers, that the term “problem gambler” is outdated, potentially harmful, and may even be used by the gambling industry to enable the avoidance of effective harm-prevention strategies (Livingstone & Rintoul, 2020; 2021). Referring to someone as a “problem gambler” reduces the individual to a “problem” and suggests blame: it places the focus on the person not the behaviour. The term “problem gambler” does nothing to reduce the stigma and shame experienced by people experiencing gambling harm. The focus should instead be shifted to the behaviour or the situation: a

person with a gambling problem or a person experiencing gambling-related harm. Referring to the situation as the problem, as opposed to the person, reduces blame and stigma.

My preference is that the later language should be used to refer to individuals with gambling problems. Having said that, I have published three articles in course of this thesis before properly scrutinising my use of the term, and these publications contain the term “problem gambler”. I have since updated the terminology used in these chapters (Chapters 4, 6 and 7) and throughout the remainder of this thesis, taking care to use language which refers to the “problem” rather than the “person” when describing individuals with gambling problems.

CHAPTER 2. TREATMENT REFUSAL AND BARRIERS TO PROBLEM GAMBLING HELP-SEEKING

This chapter will provide a review of the literature concerning treatment refusal and known barriers to help-seeking for people with gambling problems. This was deemed important given reported low rates of help-seeking. Further, it provided an opportunity to gain any known insights concerning barriers in the context of gambling venue staff and intimate partners. First, literature concerning non-help-seeking among individuals with gambling problems will be discussed (2.1) followed by a discussion of the opportunities that families may provide in influencing help-seeking. This section will include a review of the literature on family-based unilateral interventions in the context of substance-use and gambling addictions (2.2). A previously published literature review of barriers to problem gambling help-seeking (Suurvali et al., 2009) will then be discussed (section 2.3) followed by a literature review that was conducted for this thesis to update this literature (2.4), and the updated literature will be synthesised with the results of the Suurvali et al. (2009) review (sections 2.4.1. to 2.4.5.).

2.1. Treatment refusal and denial

Studies of help-seeking among individuals with gambling problems consistently report very few (less than 10%) of gamblers seek formal help (Braun et al., 2014; Cunningham, 2005; Suurvali et al., 2008). Problem gambling and its consequences can remain hidden within families, usually over extended periods, and help-seeking is often the last resort after significant adverse events or crises such as family breakdown, loss of employment, legal issues, or deterioration of mental health (Evans & Delfabbro, 2005; Productivity Commission, 2010). In view of this, it is conceivable that the vast majority of individuals living with a partner with a gambling problem are living in a situation where the gambler is either not seeking help, resistant to help-seeking and in denial of their problem, and/or unaware of the

extent of the problem and its impact on their partner. With this in mind, it is notable that much of the research concerning families of gamblers with problems has been conducted with clinical populations; that is, in situations where the gambler is receiving help. Whilst insights gained from such research are useful and provide some understanding of the negative effects of living with a partner with a gambling problem, we cannot assume that the experiences of partners living in situations in which the gambler is actively seeking help, are the same as those in situations where the gambler is not receiving help or is in denial of the problem.

In the absence of such research concerning partners of individuals with gambling problems, we can look to the substance use disorders literature, where the negative impact of problematic substance use on families is well documented (Rotunda & Doman, 2001). Similarly, help-seeking for substance-related addictions such as alcohol, is exceedingly low (Korcha et al., 2013), with denial reported as the primary reason individuals with alcohol and or opiate problems refuse treatment (Gastala, 2017; Pickard, 2016). Despite this, the concept of denial appears to have received limited empirical attention in the substance addiction literature (Pickard, 2016), particularly concerning its impact on partners. The issue of denial, however, has been reported within the broader context of families impacted by problematic substance use. For example, children of substance misusing parents are particularly affected by denial, as they find it almost impossible to ignore the presence of the problem and are conflicted about keeping it a secret from those outside the family (Kroll, 2004). Furthermore, such secrecy and denial can hamper children's capacity to trust their own perceptions (Kroll, 2004). Strained communication, including continual arguing or withdrawal, is a common impact of problematic substance use on interpersonal relationships (Wilson et al., 2019). Moreover, where denial is addressed and couples can discuss concerns about substance use openly together, communication is improved (Wilson et al., 2019).

Individuals with alcohol problems that do seek help, frequently report receiving pressure from a variety of formal and informal sources (Korcha, et al., 2013). Likewise, there is some evidence that individuals with gambling problems who have sought help, report pressure from family as an important motivator for their help seeking (Cote et al., 2020; Pulford et al., 2009). Families, therefore, are thought to have a significant influence on gamblers' acknowledgement of their problem and their decision to seek help (Clarke et al., 2007). Nevertheless, research directly focusing on families in situations where the gambler is resistant to seeking help and or does not acknowledge the problem appears to have been completely overlooked.

2.2. Families may be able to influence help-seeking

The idea that families or concerned significant others (CSOs) may provide an opportunity to help motivate non-help-seeking individuals with addictions to seek help is not new. Cognitive behavioural interventions involving CSOs have been researched in the area of substance addiction since the mid-1980s. First developed by Sisson and Azrin (1986) for alcohol problems, the Community-Reinforcement Approach (CRA), for instance, educates substance users and their CSOs to manipulate environmental contingencies which encourage or discourage substance use (Sisson & Azrin, 1986). The approach was then further developed for situations in which individuals absolutely refuse to engage in treatment (Meyers & Smith, 1995). Whereas CRA involves both substance users and their CSOs, Community Reinforcement and Family Training (CRAFT) is a unilateral intervention that teaches CSOs strategies aimed at reducing positive reinforcement for substance use whilst rewarding sobriety (Meyers et al., 2005). The distinction between CRA and CRAFT is that the latter does not require the addicted individual to be involved or even to be aware of the intervention. CRAFT methods have generally been shown to be effective in helping CSOs motivate their non-help-seeking or treatment-refusing alcohol, cocaine, or opioid dependant family member into treatment (Abbott, 2009; Roozen et al., 2004). A similar yet briefer

unilateral approach for partners of alcohol-dependent individuals was developed by Barber and Crisp (1995) and likewise successfully motivated treatment-refusing dependent individuals into treatment (Barber & Gilbertson, 1996, 1998).

There have been four attempts at adapting the CRAFT model to assist CSOs of individuals with gambling problems to influence treatment-refusing gamblers (Hodgins, Toneatto, et al., 2007; Magnusson et al., 2019a; Makarchuk et al., 2002; Nayoski & Hodgins, 2016). Though there was some limited evidence that the wellbeing of CSOs improved, treatment uptake rates of the gamblers were low with no significant differences between the CRAFT and control conditions. One possible shortcoming of the CRAFT research with CSOs of individuals with gambling problems to date is that we know almost nothing about the lives of individuals living with treatment-refusing gamblers with problems. CRAFT models were originally developed for use in situations involving substance dependence. Indeed, there is some evidence that the private worlds of CSOs of individuals with gambling problems are uniquely different from those of CSOs of alcohol-dependent individuals. For instance, partners of people with gambling problems have reported that detecting gambling behaviour was not as easy as detecting drinking, which added to their distress (Heineman, 1987). Further, Makarchuk et al. (2002) reported that difficulty in identifying precisely when gambling has occurred was the biggest challenge to modifying the CRAFT materials for use in the context of problem gambling. If CSOs of gamblers are unable to reliably detect gambling behaviour, then CRAFT interventions would prove challenging to apply effectively in this context; a point similarly raised by Magnusson et al. (2019). The literature reviewed highlights the pervasive impact of problem gambling on partners, and the potential, albeit early indications, that partners may be able to lessen denial among un-admitters and encourage help-seeking. This highlights the need to better equip families of individuals with gambling problems both to protect their own wellbeing and encourage their loved ones to seek treatment (Hing, Tiyce, et al., 2013).

2.3. What is known about barriers to help-seeking among people with gambling problems?

There has been growing interest among researchers over the past decade in investigating barriers to help-seeking among people with gambling problems. A greater number of barriers to treatment, such as negative treatment perceptions, privacy concerns, and time constraints, has been shown to reduce the likelihood that affected gamblers considering treatment will follow through and attend a service (Khayyat-Abuaita et al., 2015). Suuravali et al. (2009) reported the results of a review of the empirical literature on barriers to problem gambling help-seeking. The review identified 19 empirical studies that examined gamblers' experiences, attitudes and opinions pertaining to help-seeking. Four key barriers were identified from the Suurvali et al. (2009) review: a wish to handle the problem alone; shame/embarrassment/stigma; unwillingness to admit the problem; and issues with treatment, such as the quality and content of treatment, knowledge of what treatment involved, along with practical issues around attending treatment and knowledge about treatment availability.

2.4. Update of the literature on barriers to problem gambling help-seeking: a narrative review

Given that the review by Suurvali et al. (2009) was conducted more than a decade ago, this chapter will present an update of the literature of barriers to problem gambling help-seeking. While the intention was not to conduct an all-encompassing formal systematic search of the literature, effort was made to ensure the search minimised selection bias and was informative and up to date. An academic librarian was consulted and assisted to run a search using the following search terms which were informed by the Suurvali et al. (2019) review: (problem gambl* or pathological gambl* or gambling disorder) and (seek* help or help-seek* or help seek* or support or treatment) and (barrier* or obstacle*). Relevant

articles were sourced though the PubMed database. The search was limited to the period July 2008 to February 2021, as the Suurvali et al. (2009) review included articles published up to July 2008. The search was conducted on the 5th of February 2021 and yielded 57 articles of which 31 were empirical studies containing information about help-seeking and problem gambling. Data were analysed using a narrative approach, specifically thematic synthesis. The 31 included articles were loaded into NVivo qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018) for coding purposes. The results of the articles were coded to represent the main themes, and coding continued until no new codes were derived (Braun & Clarke, 2006). The results were then compared with the Suurvali et al. (2009) review.

The synthesised results of the updated search were largely consistent with the four key barriers identified by Suuravali et al. (2009) along with the addition of another barrier relating to treatment seeking obstacles for cultural minority groups which emerged from the more recent literature. There were also several additional barriers reported across studies that did not fit into the dominant barrier themes. In the updated synthesis of this literature, the barrier "a wish to handle the problem alone" as per the Suuravali et al. (Suurvali, Cordingley, et al., 2009) review, was incorporated into the two themes "adverse emotions related to perceived stigma" and "practical issues related to seeking help", since these were the reasons given for gamblers indicating they wished to manage their problem without formal assistance.

In summary, from the literature reviewed on barriers to problem gambling help-seeking, the dominant themes emerging can be grouped into four main categories:

- adverse emotions related to perceived stigma associated with having a gambling problem
- lack of awareness of having a problem or of the severity of the problem

- practical issues concerning available help, such as awareness of gambling help services and what treatment entails
- obstacles affecting cultural minority groups

These will be described in the following sections along with several additional barriers which were reported across the articles.

2.4.1. Adverse emotions related to perceived stigma

Stigma is an attribute that carries devalued stereotypes and is discrediting of one's behaviour, identity, or status (Goffman, 1963). Mental health stigma is a barrier that has been demonstrated to influence self-perception, interpersonal relationships, and mental health including treatment seeking (Sickel et al., 2014). Adverse emotions related to perceived stigma of having a gambling problem were the most frequently reported barrier to help-seeking. To avoid unwanted emotions related to stigma, individuals with gambling problems avoid seeking help, even when such avoidance behaviour causes them harm in the long term. The phenomenon of avoiding unwanted thoughts and feelings at all costs, even when doing so causes harm to the individual, is referred to as experiential avoidance (Hayes et al., 1996). Experiential avoidance has been shown to be positively and significantly related to problem gambling severity (Riley, 2014). That is, individuals with more severe gambling problems make greater attempts to avoid unwanted emotional experiences. Thus, if the act of help-seeking elicits adverse emotions such as shame, and problem gambling is related to experiential avoidance, it is unsurprising that individuals with gambling problems avoid seeking help.

Shame about one's mental illness is strongly related to stigma and has therefore been considered "self-stigma's emotional side" (Rüsch et al., 2014, p. 178). Shame was the most frequently reported adverse emotion across studies (Baxter et al., 2016; Evans & Delfabbro,

2005; Fong, 2005; Gainsbury, Hing, et al., 2014; Pulford et al., 2009; Rockloff & Schofield, 2004; Suurvali, Cordingley, et al., 2009; Tavares et al., 2002; Wieczorek & Dąbrowska, 2018), with some studies reporting both shame and embarrassment (Evans & Delfabbro, 2005; Itapuisto, 2019; Rockloff & Schofield, 2004). One study revealed that shame was related specifically to financial difficulties, which posed a barrier to help-seeking (Baxter et al., 2016).

The decision to undertake treatment was found by Dabrowska et al. (2016) to involve the disclosure of a number of facts such as stealing and cheating from family and losing large amounts of money, which contributed to shame and stigmatisation for the person with the gambling problem. Several studies indicated differences in how shame was experienced by different demographics; for example, shame and embarrassment were more prevalent among male gamblers and older participants (Rockloff & Schofield, 2004). Gender differences were also reported with men indicating shame was related to acknowledging a loss of control, such as gambling had taken control of their life, and shame around using gambling to cope with difficult emotions (Baxter et al., 2016). Women, on the other hand, indicated shame in admitting they enjoyed the bells and whistles and seductive features of the gambling environment, and shame acknowledging gambling-related erroneous beliefs, such as that the casino can be beat, which made them feel belittled (Baxter et al., 2016). While men and women both experienced stigma concerning their loss of control, men viewed it as a personal failure, whereas women were embarrassed that their gambling got out of control because they were enticed by venue perks (e.g., free food, VIP status) and their beliefs in luck (Baxter et al., 2016).

2.4.2. Lack of awareness of having a problem

Denial or lack of awareness of having a gambling problem was reported widely across studies (Evans & Delfabbro, 2005; Gainsbury, Hing, et al., 2014; Gupta & Stevens, 2021;

Kaufman et al., 2017; Pulford et al., 2009; Rockloff & Schofield, 2004; Suurvali, Cordingley, et al., 2009; Tavares et al., 2002), with some gamblers indicating they lacked an awareness of their problem's severity (Gupta & Stevens, 2021; Suurvali, Cordingley, et al., 2009; Tavares et al., 2002) rather than complete denial. There was some indication that women were more likely to acknowledge denial as a barrier to help-seeking than men (Rockloff & Schofield, 2004), and that it often took a significant negative event or crisis for gamblers to overcome their denial and seek help (Evans & Delfabbro, 2005; Kaufman et al., 2017). An Australian study by Hing et al. (2016) revealed that denial of the problem and avoidance of help-services was related to stigma, in that acknowledging the problem and seeking help would confirm the presence of the gambling problem to the individual and others. This finding is consistent with the findings reported by Dabrowska et al. (2017) who found the perceived stigma and self-stigma from disclosure of shameful behaviours often accompanied the acknowledgment of a gambling problem.

2.4.3. Practical issues concerning available help

In addition to stigma and denial, practical issues around available help was reported as a barrier to help-seeking (Gainsbury, Hing, et al., 2014; Rockloff & Schofield, 2004; Tavares et al., 2002). Lack of money, time, or transportation to attend help services was cited as a barrier (Guilcher et al., 2016; Tavares et al., 2002) along with a lack of awareness of available help services (Gainsbury, Hing, et al., 2014; Kaufman et al., 2017; Rockloff & Schofield, 2004; Wieczorek & Dąbrowska, 2018). A more recent Australian study reported that some gamblers could overcome their feelings of shame but did not have the necessary information about available help services (Gainsbury, Hing, et al., 2014), consistent with the findings of a study by McMillen et al. (2004) who reported gamblers deemed the availability of treatment services as inadequate and that information on help-seeking was hard to find.

Contrary to these studies, an Australian study that investigated barriers and motivators for help-seeking among gamblers with problems, however, found little evidence that a lack of awareness or a dislike of counselling services presented a barrier (Evans & Delfabbro, 2005). Whilst the evidence is mixed, as shown by these various studies, the majority of that evidence does indicate that a general lack of awareness of available treatment services is an important barrier to help-seeking. In particular, a lack of knowledge and availability of specialist treatment services designed exclusively for people with gambling disorders, as opposed to more generalised addiction services that mostly accommodate individuals with alcohol and other drug problems (Dąbrowska et al., 2017; Wieczorek & Dąbrowska, 2018).

2.4.4. Cultural minority groups

Several studies focused on cultural minority groups and reported specific barriers which discouraged them from seeking assistance for gambling related problems. Cultural minority groups were reported to be particularly affected by shame related to gambling problems (Gainsbury, Hing, et al., 2014) and often attempted to manage the problem within the family (Fong & Tsuang, 2007). Studies of Indigenous Australian individuals with gambling problems have reported that denial of gambling problems and reluctance to seek help derive from stigma and feelings of shame (Hing et al., 2014). Migrants in the United Kingdom reported limited awareness of available services, and their experiences of obtaining information about problem gambling help services indicated that these services were inaccessible to people without a good understanding of English (Bramley et al., 2020). In addition, some migrants were unaware of what the term “help” entailed. For example, some migrants believed that seeking help implied prescribed medication, and they were unfamiliar with what talking therapies involved (Bramley et al., 2020). The traditional response to crises among Asian-American Pacific Islanders, of either denial or attempt to handle problems within the family itself, was reported to pose a barrier for seeking help for gambling related problems (Fong & Tsuang, 2007). Among Chinese migrants living in Western countries, obstacles that deterred

help-seeking included language barriers, and not having sufficient information and financial means to access help for gambling problems (Chee & Lui, 2021). Further, within Chinese culture, the collective needs are prioritised over individual needs, and an individual's personal problems should not affect the larger group; hence, there may be a reluctance for affected individuals to acknowledge a gambling problem or ask family or friends for assistance (Chee & Lui, 2021).

2.4.5. Additional barriers

Several additional unique barriers were reported across studies. Women reported reluctance to acknowledge their problem and seek help, due to concern that they would lose their only social outlet (Rockloff & Schofield, 2004). In addition, the belief that the gamblers' financial problems could be solved by winning, was related to avoiding help-seeking (Tavares et al., 2002). Another notable finding was that the more recent the gambling problem was, the less likely the individual was to delay help-seeking (Tavares et al., 2002). The authors provided one possible explanation for this outcome by suggesting that greater public awareness and treatment availability took place in the city concerned, during the previous few years. They argued that this particular finding highlights the importance of availability and ease of access to treatment services. One study investigated help-seeking via the use of gambling venue self-exclusion and found that key barriers comprised an overly complicated enrolment process, inadequate available information and support from venue staff to enact the self-exclusion, and the lack of complete exclusion from all venues (Motka et al., 2018).

Another impediment to gamblers seeking treatment was suggested by Hakansson and Ford (2019) who investigated the general Swedish population's view of where to seek help for gambling problems. The authors reported that the general population largely did not view problem gambling as an issue requiring professional treatment, and they may therefore recommend informal avenues of support for people with gambling problems such as friends

and family. A recent study in Finland (Itapuisto, 2019) reported strong gambling culture as a key barrier in that it does not discriminate between problem and recreational gambling. The findings indicated that gambling venues reassured gamblers that gambling is normal behaviour irrespective of the extent of gambling harms on the individual.

In summary, stigma: perceived public stigma and self-stigma, are a particularly common experience among gamblers with problems, and appear to be tremendously detrimental to help-seeking. Lack of acknowledgement of having a problem presents another important barrier, which in some cases could be related to perceived stigma. Lack of acknowledgmement of having a problem may also stem from difficulty distinguishing between recreational and problem gambling, which may be a result of a lack of understanding of the disorder by the general population, and a strong gambling cultutre. In addition, a general lack of awareness of available help services appears to be another important barrier, particularly among culturally and linguistically diverse individuals.

CHAPTER 3. THE ROLE OF LAND-BASED GAMBLING VENUE EMPLOYEES IN FACILITATING PROBLEM GAMBLING HARM REDUCTION AND HELP-SEEKING: A COMPREHENSIVE REVIEW

3.1. Introduction

The purpose of this chapter is to review the literature on gambling venue staff and their role in harm minimisation in land-based venues which contain EGMs. The term land-based venues is used to distinguish between online gambling and gambling that occurs in a licenced "bricks and mortar" establishment. Previous literature reviews will be discussed in terms of their findings and the gaps in research highlighted (3.1.2) ahead of an outline of the aims of this review (3.1.3). The systematic search strategy applied to source peer-reviewed and grey literature is then detailed (3.2.) A total of 121 items were synthesised and the results were arranged and presented across five categories: (1) the identification of gamblers with potential problems in the venue; (2) gambling venue staff responses to patrons of concern; (3) gamblers' perspectives around venue responsibilities and interactions with patrons of concern; (4) corporate social responsibility programs and the identification of gamblers with problems in the venue; and (5) gambling venue staff needs (3.3.). This is followed by a discussion (3.4.) including gaps in the literature and directions for future research.

Over the past decade greater emphasis has been placed on the role of the gambling industry to respond to problem gambling behaviour in the venue. Gambling venue staff can serve as an important interface in communicating responsible gambling information and strategies to gamblers (Dawson & Abbott, 2011; Ponting et al., 2016; Quilty et al., 2015). There has been particular interest in the degree to which gambling venue staff can identify patrons of concern and take an active role in intervening before further harm is endured. Though several studies have investigated whether it is possible for gaming room staff to

reliably identify patrons with potential gambling problems (Blaszczynski, 2002; Delfabbro, King, et al., 2012; Schellink & Schrans, 2004), information available advising of best practice responses by gambling venue employees once such identification has occurred, is scarce.

3.1.1. Gaming venue employees, an opportunity to facilitate help-seeking

Given the general reluctance of individuals with gambling problems to seek help (Evans & Delfabbro, 2005; Gainsbury, Hing, et al., 2014; Suurvali, Cordingley, et al., 2009; Tavares et al., 2002) and reported low levels of awareness of help services among affected gamblers (Gainsbury, Hing, et al., 2014; Hing & Nuske, 2012a), gambling venues may provide a valuable opportunity to inform patrons of available help services. This may be by way of staff interaction with patrons, or in passive form such as signage, pamphlets and like resources in the venue. Consequently, gaming room resources and staff interactions with patrons have important public health implications. The following review will focus on staff interaction with patrons, given venue staff are among the first point of contact for individuals looking for help with gambling problems (Productivity Commission, 2010). Frontline gambling venue staff therefore provide an important gateway to encourage patrons of concern to seek treatment, and to facilitate referrals (Hing & Nuske, 2012a). Despite this, there is relatively little literature examining how gambling venue staff respond to problem gambling behaviour in venues.

3.1.2. Previous literature reviews

Seven previous publications have reviewed literature on approaches to harm reduction in land-based gambling venues which included specific content about the role of venue staff: six peer-reviewed articles (Beckett, et al., 2020; Forsström et al., 2021; Ladouceur et al., 2017; Livingstone et al., 2014; Skarupova et al., 2020; Tanner et al., 2017) and one technical report (Blaszczynski et al., 2014). Other reviews of gambling operators' harm reduction strategies such as Tanner et al. (2017) have focused on behavioural protective

strategies (e.g., self-exclusion or card-based gambling programs) without addressing the role of venue staff. None of the previous reviews have focused specifically on land-based gambling venue staff involvement in problem gambling harm reduction and interactions with gamblers.

Livingstone et al. (2014) conducted a review of the evidence base of eight identified land-based venue strategies: self-exclusion, signage, messages on EGM screens, staff identification and interaction with gamblers, Smart-card and pre-commitment technology, removal of automatic teller machines (ATMs) from gambling venues, responsible gambling codes, and reduction in maximum bets. The review included articles published between 1992 and 2013. The aim of the review was to assess the evidence base of identified strategies and so only empirical studies were included from both peer-reviewed and grey literature sources. Self-exclusion programs and the removal of ATMs from gambling venues were reported to contain a 'modest' level of evidence. Concerning the identification of and subsequent interaction with gamblers with potential problems by venue staff, Livingstone et al. (2014) concluded there was little evidence for the effectiveness of harm reduction practices where venue staff identify and interact with gamblers of concern. Moreover, based on the literature reviewed, the authors found little evidence to support the likelihood of staff correctly identifying and intervening in problem gambling behaviours, and there were indications that once identified, venue staff may be reluctant to intervene.

Tanner et al. (2017) conducted a review of harm reduction strategies implemented by industry and included both land-based and online gambling. Harm minimisation approaches examined included both environmental-level such as legislated hours of opening and a cap on the number of EGMs and industry-level which included strategies such as pop-up messages displayed on screens, both EGMs and online gambling devices (e.g., self-appraisal prompts and clocks), and removal of ATMs from venues. The search was conducted between April and August 2015 and all articles included were quantitative

empirical studies which included a measure of each strategies' effectiveness. As such, literature concerning interactions between venue staff and gamblers was outside the scope of the Tanner et al. (2017) review given, as pointed out by Livingstone et al. (2014), the lack of empirical studies on this topic. The Tanner et al. (2017) review of 27 included studies found that the harm minimisation strategies that were most effective included self-appraisal pop-up messages, $1 maximum bets, removal of large note acceptors and ATMs, reduced operating hours, and smoking bans.

Skarupova et al. (2020) conducted a review of strategies implemented by online and land-based gambling operators concerning the identification of and early intervention for gambling problems. Articles were included if they contained a systematic description of onsite identification of or intervention with gamblers with potential problems. The search was performed between September and November 2015 which yielded 67 articles. Concerning problem gambling identification and early intervention in land-based environments, the review reported that strategies mostly involved venue staff monitoring for behavioural indicators such as emotional reactions to play (e.g., irritability, complaining, crying), gambling habits (e.g., long sessions, no breaks, frequent ATM withdrawals), and social activity (sitting along, avoids company, neglected appearance). Skarupova et al. (2020) concluded that despite the availability of a broad range of known indicators for the potential identification of gamblers of concern in the venue, several obstacles hindered a proactive approach by staff. For instance, staff's reluctance to approach gamblers of concern was related to short term inconstant monitoring due to varied shifts, and a lack of staff confidence in making uninvited approaches related to harm minimisation. In concurrence with Livingstone et al. (2014) and Tanner et al. (2017), Skarupova et al. (2020) highlighted the lack of sufficient evidence about the effectiveness of gambling venue-based harm reduction strategies.

Beckett et al. (2020) conducted a systematic review of empirical studies that investigated the effectiveness of responsible gambling training for land-based gambling venue staff. Many

jurisdictions with legalised gambling require gambling operators to participate in responsible gambling training, such as Canada (Quilty et al., 2015) and Australia (Roberts, 2008). Accredited responsible gambling training is mandated in most states and territories in Australia (South Australia [SA], Australian Capital Territory [ACT], New South Wales and Tasmania), and actively encouraged in Victoria, Northern Territory and Queensland, with SA and the ACT possessing the most rigorous government regulations concerning responsible gambling codes (Roberts, 2008). For instance, SA and ACT are the only Australian states that require by legislation, gaming room staff to play an active role in identifying gamblers with potential problems (Roberts, 2008). Training for gambling venue staff, therefore, is an important part of responsible gambling programs. Synthesised findings of the 22 empirical studies included in Beckett et al.'s (2020) review suggested that the programs did improve staff knowledge and confidence in managing individuals experiencing gambling harms, however, they lacked provision of practical skills for dealing with difficult situations. The results of the review suggested that training programs should pay particular attention to staff interactions with patrons of concern, especially in challenging situations. Several methodological weaknesses (e.g., lack of comparative control group and baseline data) were reported across the studies which precluded the researchers from drawing any conclusions as to the effectiveness of the training programs in reducing gambling-related harm (Beckett, Keen, Angus, et al., 2020).

Forsstrom et al. (2021) conducted a systematic review and meta-analysis of the effectiveness of education programs and consumer protection measures for both land-based and online gambling. Following a review of the 26 included publications concerning responsible gambling measures, the authors concluded that the certainty of the evidence of responsible gambling measures was low, and the long-term effects are unknown. There was no evidence reported regarding venue staff interactions with gamblers.

Ladouceur et al. (2017) reviewed peer-reviewed empirical evidence underpinning responsible gambling strategies and examined only studies that were conducted using in-situ gambling environments, and at least one of the following criteria: a matched control or comparison group, repeated measures, and one or more measurement scales. The review of 29 included studies highlighted five specific areas of scientific research concerning responsible gambling strategies: (1) self-exclusion; (2) gambling behaviour to develop algorithms that can identify problem gambling; (3) limit setting; (4) responsible gambling EGM features; and (5) staff training. The only area that included findings related to staff interacting with identified gamblers of concern was staff training. The review concluded that interactions between staff and gamblers around problem gambling, and the identification of gamblers with potential problems by venue staff, represented a significant challenge, and empirical research in this area remains underdeveloped. Only six of the studies included all three criteria for scientific rigour. The authors concluded that few responsible gambling strategies that could be considered as “best practices”.

Blaszczynski et al. (2014) reviewed operator-based approaches to gambling harm minimisation for land-based and online forms of gambling. The authors suggested that the current model of responsible gambling is overtly passive and reactive. Concerning venue staff, they concluded that staff are reluctant to intervene with gamblers suspected of having problems because they feel they lack proper training to handle sensitive potentially difficult interactions. In addition, attempts should be made to engage the player with responsible and problem gambling guidance before significant harm is experienced. The review called for adequate training for staff in responsible gambling and proposed “candid specification of staff responsibilities would increase staff self-efficacy in this context” (Blaszczynski et al., 2014, p. 80).

Of the seven literature reviews on approaches to harm reduction in land-based gambling venues described above, five reported on staff engagement with identified gamblers of

concern (Beckett et al., 2020; Blaszczynski et al., 2014; Ladouceur et al., 2017; Livingstone et al., 2014; Skarupova et al., 2020). Overall, the literature suggests there is little evidence that the identification of and engagement with gamblers of concern by venue staff does anything to reduce gambling-related harm (Livingstone et al., 2014). Venue staff have identified that engaging gamblers about problematic gambling is a significant challenge (Ladouceur et al., 2017; Skarupova et al., 2020) as staff lack confidence (Livingstone et al., 2014; Skarupova et al., 2020) and are therefore reluctant to do so (Beckett et al., 2020; Blaszczynski et al., 2014). Further training of staff that focuses on the engagement of gamblers of concern was suggested as a strategy to increase staff confidence (Beckett et al., 2020; Blaszczynski et al., 2014).

3.1.3. Aims of the current review

The previous reviews have focused on either empirical studies only (Livingstone et al., 2014; Tanner et al., 2017) or both online and land-based gambling environments containing all forms of gambling (Škařupová et al., 2020; Tanner et al., 2017), and included literature up until 2015 (Škařupová et al., 2020; Tanner et al., 2017). The present review takes a narrower focus by examining harm minimisation approaches used by employees of land-based venues which operate EGMs and takes the opportunity to update the literature.

In this chapter, both peer-reviewed and grey literature on the gambling venue employees' role in facilitating harm minimisation and help-seeking for gamblers are reviewed. As EGMs are among the most frequently reported form of gambling by gamblers with problems (Armstong & Carroll, 2007; Productivity Commission, 2010) and the majority of gambling expenditure in Australia emanates from casinos and EGMs (Queensland Government Statistician's Office, 2021), this review is limited to casinos and land-based venues containing EGMs (i.e., not venues which only operate horseracing, sports betting, lotto, keno). This study aims to review the strategies, practices, and policies employed by land-

based gambling venues concerning their employees' role in preventing gambling-related harm and responding to problem gambling behaviours. The aim is not purely to evaluate the evidence, rather, to describe and summarise the literature and strategies used by venue staff and assess the evidence where available.

Given a large amount of gambling research along with gambling harm minimisation policies are published in government reports and gambling venue websites, that is, outside peer-reviewed journals, to fully inform this study, grey literature was included in the review. Grey literature has been defined as "that which is produced on all levels of government, academics, business and industry in print and electronic formats, but is not controlled commercial publishing, primarily where publishing is not the primary activity of the producing body" (Luxembourg, 2004, p. iii). See also Farace (1998).

Peer-reviewed literature was obtained by a search of the academic electronic databases for articles on gambling venues' responses to problem gambling. Grey literature was obtained through three strategies. First, a search was undertaken of websites for relevant documents published on the Internet. Second, targeted websites of gambling help services and gambling research centres at both national and international levels were searched. The final synthesis of the findings from this review offers a review of previous research, with a specific focus on current practices concerning gambling venue employees' role in harm minimisation and assisting affected gamblers to seek help.

3.2. Methodology

A systematic approach was applied to this study to search for literature on land-based gambling venue employees' role in facilitating problem gambling help-seeking and harm minimisation. Items were obtained from both peer-reviewed and grey literature sources. A research librarian was consulted to assist with developing the search strategy for the peer-

reviewed literature. Four electronic databases were searched: Scopus; ProQuest; PsycInfo; Web of Science. Titles, abstracts, and keywords were searched using the following terms: "Gambl* AND (policy or policies or referral or staff or employee or "support program") AND (gambling venue* OR casino* or hotel* or hospitalit* or "gaming room*")".

The strategy outlined by Godin et al. (2015) was applied to identify grey literature and comprised the following strategies: Google search engine (Google Advanced Search); targeted websites. This included limiting the hits screened to the first 10 pages of the search's output (approximately 100 websites) on the expectation that these will be the most relevant (Godin et al., 2015). Keywords used for the Google Advanced Search included: "casino" or "hotel" or "venue" or "staff", and "problem" or "gambling" or "problem gambling" or "responsible gambling" or "gambling disorder" or "pathological gambling", and "refer" or "identify" or "approach" or "help" or "assist". The search was limited to English-language documents.

To search targeted websites, a Google search was first conducted to locate websites of gambling help services and gambling research centres at both national and international levels. Websites were examined to identify documents containing information on gambling venue employees' role in facilitation problem gambling harm minimisation and help-seeking. Discussion among the research team, existing expert knowledge, and review of the Google Advanced Search hits helped guide the selection of targeted websites. Following this, pertinent websites were searched 'by hand' for potentially relevant documents (Godin et al., 2015). Additionally, the Gambling Research Exchange Ontario (GREO) evidence database was searched using the terms "venue" and "employee" for relevant grey literature. The search processes for the both grey and peer-reviewed literature were performed on the 24th of February 2021.

3.2.1. Inclusion and exclusion criteria for the review

Documents were included if they were written in English and contained information about employees of land-based venues that operate EGMs, involvement with problem gambling harm minimisation and the facilitation of help-seeking. Given the expansion of legalised gambling opportunities, particularly casinos and EGMs, and a coinciding increase in problem gambling rates in Australia and North America in the early 1990s (Williams et al., 2012), alongside changes in gambling policy and legislation over this period, for instance, casinos in America and Australia began implementing responsible gambling programs and policies in the 1990s (Hing, 2003; Hing, 2010), articles and documents published in 1990 and later were included. Documents could be empirical studies or documents published by gambling venues containing information about the venue's harm minimisation policy. Table 1. presents the inclusion and exclusion criteria.

Table 1. Inclusion and exclusion criteria for the review

Inclusion criteria	**Exclusion criteria**
English language Published in 1990 or later	Documents not in English Published before 1990
Peer-reviewed journal articles or grey literature from the following categories: conference proceedings, theses/dissertations, books, commentary articles, reports	Literature review and research protocols PowerPoint presentations, information on a webpage not in Pdf or another downloadable format
The venue contains electronic gaming machines (inc. video lottery machines) and is land-based including hotels, community/sporting clubs and casinos	The focus of the venue is sports betting, horse racing or other wagering, and does not operate electronic gaming machines. Online gambling
The document contains information on gambling venue employees' response to problem gambling or the promotion of harm minimisation	The document does not address gambling venue employees' response to problem gambling or the promotion of harm minimisation

3.3. Results

A total of 1539 documents were located. Peer-reviewed articles obtained from the database search were combined into an Endnote library for screening and duplicates removed. Inclusion criteria were then applied to the remaining 939 documents resulting in 81 documents requiring a full text read. The GREO database search resulted in 351 documents of which 17 met inclusion criteria. Targeted websites and the Google Advanced search resulted in a further 11 included documents. In total, the search of academic databases and other internet sources resulted in 62 peer-reviewed articles, 3 books, and 36 grey literature documents. Backward snowballing was then employed to search the reference lists of included documents (Horsley et al., 2011) and the results were checked against the inclusion and exclusion criteria with the research supervisors. This process yielded an additional 19 items: 17 journal articles and 2 grey literature documents. Figure 1. presents the results of this process in a PRISMA flow diagram.

The 121 documents included in the review were loaded into NVivo Qualitative Data Analysis Software (2018) for coding purposes. While it is most commonly used for qualitative data analysis, NVivo is an effective tool for performing literature reviews (Bandara et al., 2015). For coding purposes, three preselected themes were used as these were considered important and appropriate to explore to achieve the research aims: the identification of gamblers with potential problems in the venue; gambling venue staff responses to patrons of concern; gamblers' perspectives around venue responsibilities and interactions with patrons of concern. During the coding process, two additional themes emerged: corporate social responsibility programs and the identification of gamblers with problems in the venue, and gambling venue staff needs. The five themes are discussed in the following section, with grey and peer-reviewed literature presented separately.

3.3.1. Corporate social responsibility programs and the identification and response to problem gambling behaviours in the venue

A range of peer-reviewed articles and grey sourced documents described and discussed gambling venues' various codes of conduct, which outlined both mandatory and voluntary rules and responsibilities of gambling operators. Many jurisdictions' gambling regulatory codes required gambling operators to employ a duty of care towards gamblers. Frequently this included staff identifying individuals experiencing gambling-related harm and rendering appropriate assistance. Whilst directives informing venue staff to observe and identify potential problem gambling behaviours among their patrons were common across the literature, much less common were clear guidelines outlining what action staff should take once risky gambling was identified.

Peer-reviewed literature

The most frequently described advice was that ground staff should document observed risky behaviours and then report them to a senior staff member or a staff member dedicated to the responsibility of managing problem gambling issues (Beckett, Keen, Angus, et al., 2020; Breen et al., 2006; Guerrier & Bohane, 2013; Hancock & Hao, 2016; Meyer et al., 2009; Thompson, 2007).

Several jurisdictions had more formal programs to identify and respond quickly to gamblers with potential problems. In Switzerland, all casinos must implement preventative measures, for instance, the early detection of patrons displaying signs of potential gambling problems. Staff must observe and prepare a report if they witness signs of problem gambling, which is examined by a supervisor. If specific risky behaviours are involved, the supervisor must approach the player concerned immediately (Thompson, 2007). In Germany, casino employees are required by law to impose forced exclusion on individuals at risk of problem gambling (Kotter et al., 2018). Unlike the responsible codes of gambling practice that form a

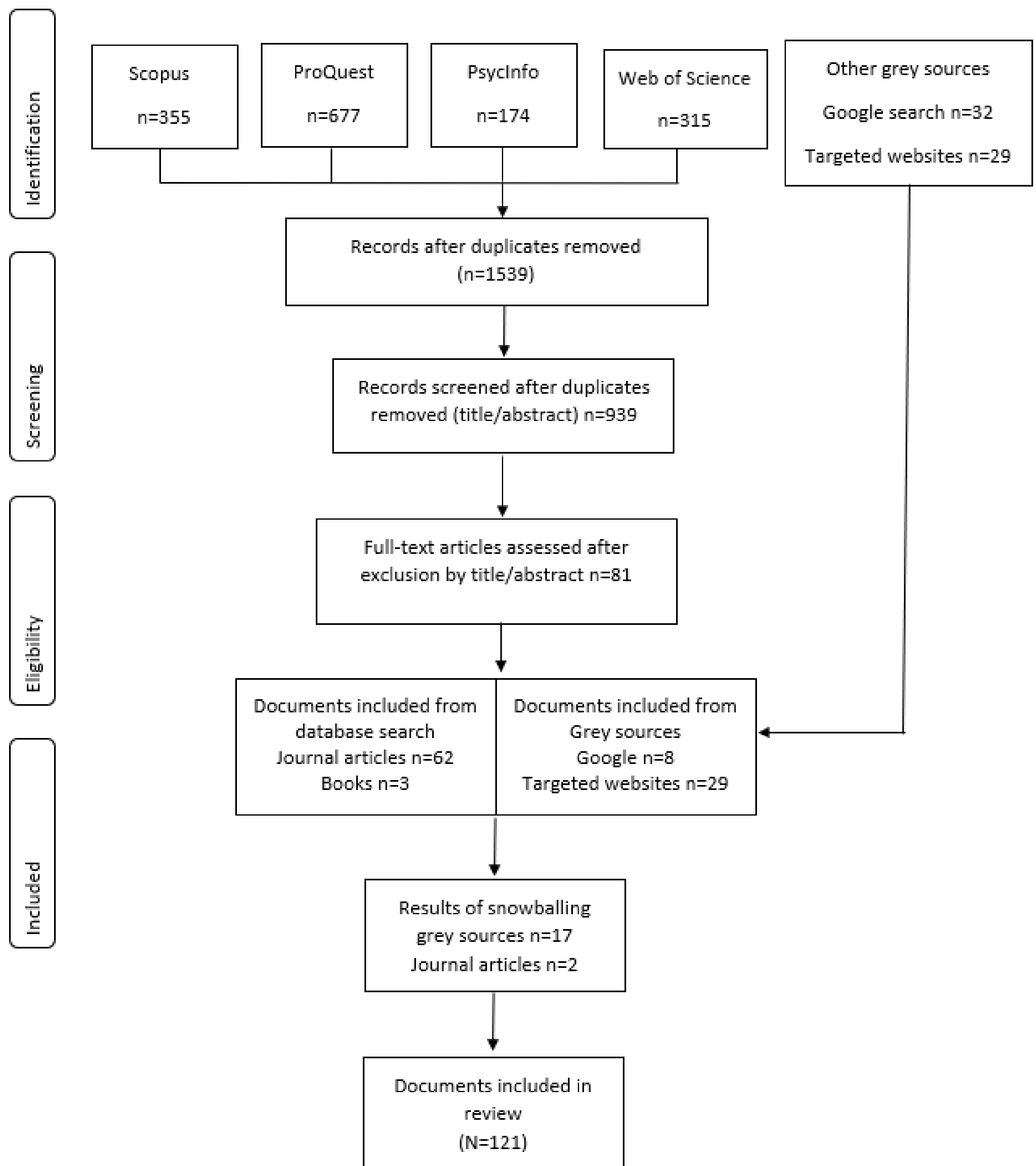

Figure 1. PRISMA flowchart for document selection.

major component of the regulation of safe levels of gambling in Australia, these more proactive approaches to preventing and responding to problem gambling are aligned more

closely with a consumer protection-orientated policy.

While the information gained via frontline staff observation was not typically recorded in any formal documentation system, some Canadian jurisdictions did report documenting and collating observable signs of problem gambling among players. For example, several Canadian casinos use an electronic monitoring system 'iCare' (intelligent player care program; Davies, 2007). The iCare system can capture and interpret data from the operator's casino management system and identify patrons deemed to be at risk. Once a patron of concern is identified, the system is enabled to notify operators when the patron is in the casino and provide staff with information about their behaviour and clear processes to follow (Davies, 2007). A dedicated onsite responsible gambling centre in a United States casino was described (Gray et al., 2020) where program staff observe and document gamblers' behaviours and engage with those displaying signs of risk.

Across the literature, studies examining the effectiveness of responsible gambling programs were lacking, however, there has been some research that has examined the implementation and effectiveness of responsible gambling regulatory codes. Breen et al. (Breen, 2005) investigated the levels of implementation of the Queensland Responsible Gambling Code of Practice in Australia and found lower implementation rates among smaller venues than those with larger gambling installations. Impediments included high staff turnover and remote locations, whilst facilitators included staff training, regular audits, and elements of the Code that overlapped with legal obligations for the gaming operator (Breen, 2005). Fiedler et al. (2020) conducted a recent review of seven responsible gambling programs of land-based EGM operators in Germany. In addition to reviewing responsible gambling programs, the researchers surveyed 512 gamblers in treatment to examine their experience of the described responsible gambling initiatives. The results of their study indicated that the responsible gambling programs reviewed contained a range of measures, most of which were mandatory except notably, those which involved staff approaching

patrons displaying problem gambling behaviours with the intention to help them. Moreover, the results of their survey revealed that almost half the gamblers reported they felt their significant losses were noticed by staff, with around a third believing that staff were aware of their problem. However, only 1% of gamblers with problems reported being approached by staff and referred to support services (Fiedler et al., 2020).

Grey literature

In Australia, and many other jurisdictions, gambling operators' duty of care to protect gamblers from gambling-related harm is stated in gambling legislation, although guidelines about how operators should achieve this are inconsistent. For instance, in Australia, some States are required to abide by mandated codes of practice enforceable by a regulatory body, while others, the gambling industry develop their codes of practice and are self-regulatory (Delfabbro et al., 2007). Regulatory laws in Switzerland are stricter, with casinos required to make every effort to prevent gambling problems arising before they become serious. Swiss casinos have a mandate to impose involuntary exclusion orders on gamblers they believe are gambling beyond their means, and the exclusion orders are applied to all casinos across the country (Delfabbro et al., 2007).

In 2012 the Canadian Responsible Gambling Council's Centre for the Advancement of Best Practice (CABP, 2012) published a report into the best practices for gaming providers to respond to patrons who may have a gambling problem. The report reviewed documentation from around the world and described the most common pathways regarding venue staff responding to identified problematic gambling behaviours which can be summarised as followed. Once frontline staff become aware of observable signs, they pass this information to their supervisor/manager or responsible gambling specialist. At this point, the supervisor may decide to approach the patron or begin the process of recording and monitoring. Based on the outcome of the monitoring period the supervisor may decide to approach the patron or that no further action is required. Approaching the patron may involve a warning

conversation or imposing a formal ban. Typically, patrons who undergo self-exclusion or venue-imposed exclusion, are encouraged to contact a local gambling help or counselling service. Staff can also provide local gambling help service information at any point during patron approaches. The report then, based on the literature and a series of focus group interviews with venue staff and gamblers suggested best practices concerning approaching patrons of concern. It stated that “successful approaches are a blend of science and art and the human element” (CBAP, 2012, p. 157). Characteristics considered essential in all patron interactions included: ensuring privacy away from the gaming floor; having a discussion where other patrons cannot overhear; using language that is non-confrontational and non-judgemental; being trained at dealing with resistance; providing take away information (CBAP, 2012).

Holland Casino, which operates 14 casinos throughout the Netherlands, utilises a visitor registration system to monitor all patrons’ visits. All casino visitors must have an identification card which they present to security personnel on entry. Visiting frequency and patterns are used to identify potential patrons of concern. For example, patrons who visit ten times in one month within the past three months, are flagged for displaying early warning signs. Once a patron of concern is identified, security personnel are alerted and then approach the patron for an interview to determine how affordable their gambling is to them, by asking details such as their income and number of dependants (CABP, 2012). As with many other jurisdictions, the most common response described in Canadian venues when frontline staff observe problem gambling behaviours was to ‘report up’ or escalate the incident by providing the information to a more senior employee (CABP, 2012). Similar to the onsite responsible gambling centre described by Gray et al. (2020) in a United States casino where gamblers are encouraged to visit and learn about how the gambling games work, talk to a GameSense advisor, or take a break (Hauck, 2018), dedicated onsite responsible gambling centres in several casinos across Canada were also described by the Canadian Centre for Advanced Best Practice report (CABP, 2012).

3.3.2. The identification of gamblers with gambling problems in the venue

Peer-reviewed literature

Research into the feasibility of venue staff identifying individuals gambling at harmful levels through observation indicates that while there appear to be a reliable set of behavioural indicators, using them effectively in practice presents several challenges. The concern around gambling operators diagnosing individuals experiencing gambling-related harms has been raised by leading problem gambling researchers (Blaszczynski et al., 2004), in particular, the use of relying solely on observable indicators (Delfabbro et al., 2016; Hing, Nuske, et al., 2013) and appears to have been reflected in the handful of studies that have endeavoured to empirically investigate if it is possible to identify individuals with gambling problems in the venue.

A study in Nova Scotia (Schellink & Schrans, 2004) investigated combinations of potential indicators that could be used to identify individuals with gambling problems with a high degree of confidence. A wide range of visible and non-visible cues, when occurring in combination during a visit, was found to have a high confidence value (90% or better) in identifying if someone had a gambling problem. The authors, however, made the point that the relatively low frequency that behavioural indicators are likely to occur, at the precise time a single onlooker might observe them, poses significant challenges for effectively using such indicators in practice. In South Australia, Delfabbro, Borgas et al. (2012) investigated the accuracy of gambling venue staff in identifying gamblers with problems in venues. The study found that venue staff were able to identify only 36% of patrons experiencing problems with gambling. Many gamblers who self-reported at least moderate gambling problems, were not classified as having any problems by staff. On the other hand, there were gamblers in the 'no risk' category classified by staff as having gambling problems. In another study, a computer-based model using an algorithm to decode observations made by trained staff about casino gamblers was developed by Ifrim (2015). When the model was run with

simulated groups of gamblers both with and without problems, it was able to identify correctly in about 95% of the cases.

Overall, the outcomes of these studies are consistent with the conclusions provided by Schellinck and Schrans (2004) and Allcock et al. (2002) in that, although it is theoretically possible to identify individuals with gambling problems using a range of behavioural indicators, there are many challenges facing venue staff if they are to rely on such indicators in practice. Delfabbro, King, et al. (2012) argued that while staff may be able to observe potential indicators, this would require a period of continuous observation that would likely be impractical for staff to perform given their other competing duties. The authors recommended that venues use multiple indicators, including observable and electronic monitoring, and consolidate information about individual patrons across multiple observers and periods of observation (Delfabbro, King, et al., 2012). This is consistent with Hancock et al. (2008) who recommended that clear protocols be developed to monitor individual patrons' indicators over time and that electronic player tracking technology should be adopted.

Along with the feasibility and accuracy of using observable indicators to detect problem gambling, venue staff's confidence in using such tools has been investigated. In general, it has been reported that staff are aware of the important elements of the definition of problem gambling and the indicators (O'Mahony & Ohtsuka, 2015), with one study reporting that collectively staff were able to identify 22 potential indicators of problem gambling (Hing & Nuske, 2011a). Gambling help counsellors have likewise indicated they believe venue staff can identify patrons of concern (Hing & Nuske, 2011a). Although the majority of venue staff involved in these studies indicated they could recognise a patron with a gambling problem (Hing & Nuske, 2011a; Hing & Nuske, 2012a; Hing, Nuske, et al., 2013; O'Mahony & Ohtsuka, 2015), some of the challenges reported included that competing work demands meant staff were not able to observe patrons all the time (Hing, Nuske, et al., 2013). In addition, staff were concerned about the potential to mistakenly identify a regular gambler as

a patron of concern, where there was no problem (false positives) (Hing, Nuske, et al., 2013).

Other research has investigated differences in observable behavioural indicators among diverse groups of gamblers. Delfabbro et al. (2018) examined differences between male and female gamblers. Signs of emotional distress were more commonly reported by female gamblers with problems, while males were more likely to display aggression towards others in the venue and the gambling machines (Delfabbro et al., 2018). O'Mahony and Ohtsuka (2015) examined how venue staff identified and perceived diverse groups of gamblers (age, gender, and specific cultural groups) concerning displaying signs of problem gambling. Staff displayed more empathy towards older gamblers, classifying them as pensioners who could not afford to lose money, and they were more sympathetic towards women, particularly if they became upset and cried. However, they were unsympathetic towards young males who they perceived as loud and aggressive and who could afford to lose large amounts of money (O'Mahony & Ohtsuka, 2015). This is concerning given young men are particularly vulnerable to developing gambling problems (Riley, Oster et al. et al., 2021).

Grey literature

Hafeli and Schneider (2006) developed a categorisation of visual indicators along with a way in which venue staff could use these to identify gamblers with potential problems. Categories comprised social behaviours (e.g., rudeness), emotional responses (anger or distress), raising funds (e.g., asking for credit) and general indicators (e.g., long sessions). The results were inconclusive, the sample was small, and the study was not peer-reviewed.

In 2002, the Australian Gaming Council released a report concerning the identification of individuals with gambling problems in venues (Allcock et al., 2002). The report was based on a series of discussion papers by leading experts who were asked their professional opinions about how to identify and respond to problem gambling behaviours in land-based venues.

The report presents a range of observable indicators that the experts agreed could potentially identify problem gambling behaviour, along with the caveat that such indicators in and of themselves, are not necessarily signs of problem gambling (Blaszczynski, 2002). Though such indicators might potentially help to identify gamblers with problems, the experts cautioned that these are indicators, not diagnostic tools. They concluded that "it is important for staff, where possible, to make an informed judgement, to distinguish between customer behaviours and to respond accordingly" (Allcock et al., 2002, p. 9). The report goes on to stress "most importantly, staff should not be involved in 'diagnosing' problem gamblers – they are not qualified, nor is it appropriate for them to do so" (Allcock et al., 2002, p. 9).

There is, however, some evidence that behavioural indicators can help staff to correctly identify patrons with gambling problems. Thomas et al. (2014) examined a checklist of indicators against a sample of 500 regular land-based EGM gamblers across Australia and found almost all 52 indicators more likely to be reported by gamblers with problems than lower risk gamblers, and that the presence of 4-5 indicators correctly distinguished gamblers with problems from those without in more than 80% of cases. Further, after a three-month pilot period using a revised 36-item checklist, venue staff were interviewed to examine its practical validity. Staff indicated the checklist was easy to use and that it assisted in the proactive identification of individuals with gambling problems, and increased confidence when managing customers.

In summary, the literature suggests that despite a general agreement concerning a range of reliable observable indicators to detect individuals with gambling problems in situ (Delfabbro, King, et al., 2012), overall, there are significant challenges facing venue staff in making accurate identifications, with some researchers proposing that identifying which gamblers have problems is more challenging than recognising alcohol impairment in the alcohol context (Hancock et al., 2008). The results of the studies reviewed indicate that the accuracy and confidence of gambling venue staff in identifying gamblers with problems is mixed. More

importantly, effective identification of individuals experiencing gambling-related harms will only be useful if it leads to appropriate and effective action (Hancock, 2011), a sentiment also offered by Livingstone et al., (2019) who concluded that while it may be possible for venue staff to identify such gamblers in situ, gambling operators must be required to implement mandated interventions once identification occurs.

3.3.3. Gambling venue staff responses to patrons of concern

Peer-reviewed literature

Responding to patrons with gambling problems in the venue can be differentiated by two distinct scenarios: a patron approaching a staff member for assistance about their excessive gambling (invited contact); and, a staff member initiating contact with an identified patron of concern about their gambling (uninvited contact). Regarding invited contact, this appears to be an exceedingly rare occurrence (Hing & Nuske, 2011a; Hing & Nuske, 2012a) with some staff reporting never having been approached (Hing & Nuske, 2011b) and when gamblers do approach staff is it mostly to seek assistance with self-exclusion programs (Hing & Nuske, 2011b). Given the significant shame associated with help-seeking as discussed in Chapter 2, this is not surprising.

Although staff have generally reported feeling comfortable and confident in responding to patrons of concern who do initiate contact (Beckett, Keen, Angus, et al., 2020; Hing & Nuske, 2011b; Hing & Nuske, 2012a), they have conveyed discomfort and apprehension dependent on the patrons' perceived level of embarrassment (Hing & Nuske, 2012a). When asked about situations involving being approached by a family member or friend expressing concern about a patron's gambling, staff were much less confident, which was due to their concerns around not wanting to breach patrons' privacy (Hing & Nuske, 2012a) and a lack of knowledge and clear procedures (Hing & Nuske, 2011b).

A study by Quilty et al. (2015) reported that, although staff found that a range of observable signs were useful in identifying patrons with gambling problems, responding to such concerns were viewed as a challenge, and staff indicated they were forbidden by management to approach patrons of concern (Quilty et al., 2015). An Australian study involving interviews and focus groups with 40 gamblers and 20 gambling professionals which included venue, treatment and policy and regulation professionals (Rintoul et al., 2017) revealed only minimal evidence of harm minimisation interactions between venue staff and gamblers. The results suggested that signs of problem gambling are normalised in venues operating EGMs and that venues often failed to respond to signs of problem gambling, in fact, encouraged it (Rintoul et al., 2017).

Studies that examined venue staff behaviour around initiating uninvited contact with identified patrons of concern, indicated that overwhelmingly, staff reported general unease and reluctance (Beckett, Keen, Angus, et al., 2020; Hing & Nuske, 2011a, 2011b; Hing & Nuske, 2012a; Hing, Nuske, et al., 2013). A major barrier identified by frontline staff concerned their fears of the potential consequences of mis-identifying and or causing distress to a gambler perceived as at risk. Such fears are recognised by some experts who have argued that "unjustified intrusion is likely not the way to promote responsible gambling" (Blaszcynski et al., 2004, p. 312).

The studies reviewed concerning venue staff interactions with gamblers identified as potentially having a problem revealed several factors that have contributed to apprehension among staff. These included a lack of prescribed procedures about how to initiate uninvited contact (Hing & Nuske, 2011b), feeling ill-equipped and fearful of a negative reaction (Hing & Nuske, 2011a) in particular an angry or even violent reaction from patrons, and concerns around invading patrons' privacy (Hing & Nuske, 2012a). One study reported that female staff were more reluctant to intervene with identified gamblers of concern due to feared potential negative reactions from the gambler (Tomei & Zumwald, 2017). However, while

uninvited contact with patrons of concern occurs infrequently (Hing & Nuske, 2011b; Hing, Nuske, et al., 2013; Rintoul et al., 2017), there was some evidence that when it did occur it could potentially be effective and lead to interventions such as self-exclusion and or referral to gambling help services (Hing & Nuske, 2011b; Hing & Nuske, 2012b).

Grey literature

Grey sources also indicated that occurrences of patrons approaching venue staff for assistance with excessive gambling was exceptionally rare (CABP, 2012; Hing, 2007; Hing et al., 2020) and some staff stated they had never approached a potentially troubled gambler (CABP, 2012). A frequently reported barrier reported across the grey literature involved staff fearing a negative response from patrons (Hing, 2007; Hing et al., 2020). In an overview of international responsible gambling initiatives prepared for the Australian Gaming Council, Blaszczynski (2001) reported that among the initiatives implemented across international jurisdictions, are policies and procedures for venue staff training in how to detect and approach gamblers displaying signs of problem gambling, though no studies of such initiatives were presented.

A study of Crown Casino's responsible gambling practices involving 225 employees (Hancock, 2010) reported that the majority of staff stated they do not approach gamblers whom they think are having problems with their gambling and would not intervene when gamblers are distressed while gambling. Hancock (2010) raised questions as to whether state governments with a vested interest in gambling derived tax revenues have too great a conflict of interest to effectively regulate gambling matters in the public interest. Results of a recent Australian study into the effectiveness of responsible gambling programs revealed that venue staff reported regularly observing gamblers displaying indicators of problem gambling, but rarely intervened by neither approaching them nor reporting up to senior management (Hing et al., 2020). In effect, most venue staff reported they would not intervene with a patron displaying signs of problem gambling because they did not feel

equipped and felt unsupported by management (Hing et al., 2020), which is consistent with the findings of Rintoul et al. (2017).

SkyCity Auckland's Host Responsibility policy (SkyCity Auckland, 2019; Telofea, 2005) includes a "problem gambler identification policy". The policy states that once staff have reasonable cause to believe a patron has a problem, they must either offer information or advice about problem gambling or issue an exclusion order within a reasonable timeframe. Similarly, SkyCity Adelaide's Host Responsibility policy states Host Responsibility staff are responsible for monitoring and identifying gamblers showing signs of problem gambling and using a "Customer Service Approach" to engage them and offer assistance (SkyCity Adelaide, 2019). One of the most detailed guidelines identified by this review on how venue staff should interact with gamblers displaying signs of harmful gambling was provided by the UK Gambling Commission (UK Gambling Commission, 2019b). In addition to detailing problem gambling indicators, the guide provides staff with specific advice about how they should interact with customers of concern to encourage the gambler to reflect on their level of gambling, and then to monitor the effectiveness of their interactions.

The Government of British Columbia (British Columbia, 2015) published a report outlining a public health plan for responsible and problem gambling, which detailed how specially trained staff (GameSense Advisors) approach identified patrons who are exhibiting signs of problem gambling, to offer them support, information, and referrals to problem gambling help services and resources. GameSense Advisors situated in US casinos were described in the previously cited peer-reviewed literature (Gray et al., 2020; Hauck, 2018).

Overall, based on the literature reviewed, while there was a range of information detailing how venue staff should respond, there was minimal evidence of the effectiveness of venue staff interacting with identified gamblers to effectively achieve harm reduction, a conclusion also reached by Livingstone et al.'s (2014) review.

3.3.4. Gamblers’ perspectives around venue responsibilities and interactions with patrons of concern

Peer-reviewed literature

Information concerning gamblers’ perspectives on venue staff’s role in problem gambling harm minimisation in the venue was scarce, and the results from studies that did examine gamblers’ perspectives on the venues’ responsibility to protect players were mixed. In a study of individuals with gambling problems who played EGMs and who had participated in a self-exclusion program, Hing and Nuske (2012b) reported that most respondents believed it was up to themselves to manage their problem and disagreed it was the venues’ responsibility. There was some indication that gamblers’ views regarding whether venue employees should do more to protect patrons from gambling related harm, were influenced by the gamblers’ level of risk. In a sample of almost 5000 regular casino gamblers in the United States, Gray et al. (2021) found that gamblers who scored positively on a brief problem gambling screening tool were more likely to view other stakeholders (e.g., casino employees, government regulators, public health officials) responsible for addressing gambling-related harm than those who scored negatively. Similarly, a study involving interviews with 348 casino gamblers reported those with gambling problems were more likely to hold the casino responsible for harm reduction than those without problems (Prentice & Woodside, 2013).

While Jackson et al. (2015) investigated land-based EGM gamblers’ perspectives on harm minimisation measures, venue staffs’ role and interaction with venue staff were not addressed. Hing (2004, 2005) conducted a study investigating gamblers’ perspectives on the efficacy of responsible gambling measures in New South Wales clubs. Although the quantitative findings did not address interactions between venue staff and gamblers (Hing, 2004), the qualitative findings reported some gamblers advocated for greater intervention by staff, for example, making them aware of the time spent gambling if they have been there for an extended period, or inviting them to discuss the extent of their gambling (Hing, 2005).

Grey literature

The 2011 Insight report (CABP, 2012) reported on three focus groups comprising individuals who had experienced gambling problems. Participants were asked about their experience and perspectives on venue staff approaching patrons about any gambling related concerns. Most participants reported they had never approached staff for assistance and that despite regularly displaying observable signs of problem gambling while gambling, they had not been approached by staff. Participants felt that staff should act if a patron requests assistance but did not want to be approached whilst they were playing. Suggestions by respondents as to when to make an uninvited approach included as players were on their way to the automatic teller machine or out the door, away from the gaming machines. Of utmost importance was keeping the conversation private and discrete. Some participants suggested sending responsible gambling information by mail/email. Many felt that the approach needed to be casual and private with some suggesting non-verbal tactics. For example, discretely providing written information such as a business card with information, so that no one would be offended.

A non-peer-reviewed qualitative study by Armstrong and Carroll (2018) in which gamblers and venue staff were interviewed, indicated very little interaction between staff and patrons in the gaming area. The conflict between venue profits, which was perceived as a key part of their role, and promoting responsible gambling was raised by several venue staff participants. Further, perceptions by gamblers of uninvited approaches by concerned staff were mixed: some gamblers indicated they would be grateful for any concern shown by staff where others stated they would be embarrassed and angry (Armstrong & Carroll, 2018).

In contrast to findings of Hing and Nuske (2012b) which indicated most gamblers favoured individual responsibility over the venue's role in problem gambling interventions, a report published by the New Zealand Ministry of Health presented a study of 495 EGM gamblers of which three quarters believed venue operators should take responsibilities to minimise

gambling-related harm, while only a third reported they were aware that staff had a professional obligation to practice responsible gambling initiatives (Ministry of Health, 2019).

3.3.5. Gambling venue staff needs

The acknowledgement of problem gambling as an important public health issue (Latvala et al., 2019; Productivity Commission, 2010; The Lancet, 2017) has placed increased pressure on gambling venues to address their responsible gambling practices and provide a safer environment to gamble, which had given rise to several unique challenges for venue staff (Hing & Nuske, 2012a). Given gaming room staff play an important role in problem gambling harm reduction, it is necessary to understand what is known about the challenges and stressors that are unique to gaming room employees. Several challenges and needs have been highlighted in the literature.

Peer-reviewed literature

Gaming room managers indicated that although they are aware of a variety of information sources on government policy and processes, they would benefit from assistance with greater clarification to help inform their responsible gambling practices (Breen, 2005). Frontline staff also expressed the need for clearer procedures and direction around indicators of problem gambling and how to approach patrons of concern (Hing & Nuske, 2012a). This was supported by Hing et al. (Hing, Nuske, et al., 2013) who point out that the Queensland responsible gambling code does not provide clear advice concerning how to determine if a patron has a gambling problem and how to respond. While gamblers rarely approach venue staff for assistance, when they do it is typically to assist with self-exclusion programs (Hing & Nuske, 2011b). However, the need for venue staff to be better equipped to facilitate self-exclusion programs was also highlighted (Motka et al., 2018; Pickering et al., 2019).

Another challenge expressed by venue staff concerned coping with increased negative emotional responses by patrons, especially anger and distress (Tiyce et al., 2013). In addition, staff have identified role conflict and role ambiguity as a source of stress (Tiyce et al., 2013) given that on the one hand, they have the role of attracting patrons, while at the same time there is an expectation that they approach patrons of concern, which may ultimately lead to driving the patron away to another hotel (Hing & Nuske, 2012a).

Exposure to players exhibiting signs of problem gambling and challenges responding to them was related to lower job satisfaction among venue staff (Quilty et al., 2015). Corporate social responsibility and an expectation of effective responsible gambling strategies were found to positively influence employees' organisational commitment and job satisfaction (Song et al., 2015). Overall, the peer-reviewed literature indicated there is a need for staff to be better equipped to sensitively respond to signs of problem gambling (Beckett, Keen, Angus, et al., 2020; Beckett, Keen, Swanton, et al., 2020; Hing & Nuske, 2011b; Hing & Nuske, 2012a; Oehler et al., 2017; Quilty et al., 2015).

Grey literature

A study commissioned by Gambling Research Australia (Delfabbro et al., 2007) also highlighted the need for venue staff to be properly prepared to be able to confidently respond to gamblers displaying problems once identified. One suggestion made by the Canadian Responsible Gambling Council's report to mitigate poor job satisfaction among frontline gambling venue staff was to provide feedback to employees about the outcomes of their interactions with patrons of concern (CABP, 2012). The authors suggested that doing so may help clarify the purpose of the employees' role in initiating help towards a troubled patron, building staff pride and job satisfaction. This proposition was supported by a peer-reviewed study that examined the relationship between responsible gambling initiatives and casino employees (Song et al., 2015).

Stress among gaming venue staff with regards to witnessing problem gambling behaviours was more common among newly hired staff (CABP, 2012), which may be explained by Rintoul et al.'s (2017) findings which indicated problem gambling behaviours are normalised in gambling environments with electronic gaming machines. That is, it may take newer staff time to become accustomed or habituate to excessive gambling behaviours.

The conclusions made by Beckett, Keen, Angus et al. (2020) concerning the training of gaming room staff are consistent with recommendations from the 2007 Gambling Research Australia report (Thomas et al., 2014), which recommended venue staff require greater specific training relating to interactions with gamblers identified as potentially having a problem. Training should include for example, explicit information on how to approach them, anger management, conflict resolution and counselling. These suggestions are consistent with findings from the Canadian Responsible Gambling Council's report on responding to patrons with gambling problems, which reported that while all staff received problem and responsible gambling training, many felt it was important to reinforce the information with refresher training (CABP, 2012).

Venue staff's attitudes towards gambling have also been reported to influence their participation and learning in responsible gambling training, for instance, women were reported to hold more positive attitudes towards such training as they saw it as an opportunity to learn about a social issue (Bybee, 2000). Cosic (2012) reported that venue staff most commonly discussed signs related to emotional responses and chasing funds as these are the most easily observable in staff. She concluded that training should therefore be targeted at increasing staff awareness of some of the less obvious signs including social behaviours and impaired control.

3.4. Discussion

The evidence concerning gambling venue employees' confidence in their ability to detect individuals with gambling problems is mixed. Overall, staff reported confidence in their ability to identify observable signs of problem gambling and less confidence in detecting which gamblers had problems. That is, being able to identify observable indicators and then judging a patron as having a gambling problem, are not the same thing. The limited research in this area suggests that in practice, staff are poor at making accurate identifications of gamblers with problems.

In general, staff report confidence in responding to patrons who initiate engagement and ask for assistance with a gambling-related problem. However, the evidence suggests that patrons rarely approach staff for assistance with a gambling problem, and staff are much less confident at responding to problem gambling behaviour by initiating uninvited contact (Beckett, Keen, Angus et al., 2020), and have less empathetic views of young male gamblers displaying signs of problematic gambling (O'Mahony & Ohtsuka, 2015). A reluctance of initiating uninvited contact with the aim of problem gambling harm reduction is largely due to fear of a negative response from patrons (Hing & Nuske, 2012a). Responsible gambling training programs appear to be effective at increasing staff knowledge about gambling and responding to problem gambling behaviours (Beckett, Keen, Angus et al., 2020), though would benefit from more detailed practical skills-based information about making sensitive responses to gamblers identified as potentially having a problem (Quilty et al., 2015).

From the literature reviewed, overall, the vast majority of activity performed by venue staff concerning responding to problem gambling involves observing and documenting risky behaviours and then discussing this internally with other venue staff. Action which moves beyond this, such as approaching and interacting with identified gamblers of concern, rarely

occurs. As previously noted by Hancock (2011), identifying individuals experiencing gambling-related harm is of little use if it does not lead to effective harm reduction action. This is an important point as the widespread activity performed by gambling operators around observing and documenting potentially risky gambling behaviours and delivering mandated staff training programs, can lead to an impression that there is sufficient harm minimisation activity occurring across the gambling industry. Whereas the evidence suggests there is very little action occurring in venues for individuals who do experience gambling problems, and the little action that does take place is almost entirely targeted towards those with obvious and significant issues who display disruptive behaviours such as aggression or violence (Hing, Nuske, et al., 2013). Further, male gamblers, who are among the highest risk of developing problems, particularly young males (Riley et al., 2021), appear to be the least likely to receive harm minimisation interactions by venue staff (O'Mahony & Ohtsuka, 2015). There were some exceptions to this, such as the more proactive mandated responses by casino staff in Switzerland (Thompson, 2007) and Germany (Kotter et al., 2018).

The overall inaction of gambling venues in directing their employees to take a more proactive harm minimisation response towards gamblers displaying signs of problem gambling, beyond that which involves observing and documenting, may also be a result of the largely self-regulatory nature of the various codes of conduct. Similar concerns have been raised by alcohol experts about self-regulatory measures and responsible drinking messages from the alcohol industry. As Fiedler et al. (2020) note, some studies argue that due to the alcohol industry's conflicting objectives: to encourage consumption in the service of generating profits whilst discouraging overconsumption, the alcohol industry purposefully produces responsible drinking campaigns for marketing purposes. The authors go further in arguing that such campaigns are not only ineffective but may in themselves be harmful by reinforcing current drinking patterns (Fiedler et al., 2020). Similarly, it has been argued that

responsible gambling messages may be acting both, as 'dark nudges' which encourage gambling, and increase gamblers' perceived stigma (Newall, 2019).

The results of this comprehensive review indicate that the role of gambling venue staff in promoting harm reduction directly with patrons, involves strategies that are largely individually focused, and there is little evidence for their effectiveness. Further, the focus is clearly on gamblers who display overt signs of impaired control. These outcomes are unsurprising given many countries have adopted a formal, non-binding responsible gambling strategy based on the original Reno 2004 Model in the United States (Blaszczynski et al., 2004; Nature, 2018), a model largely based on individual responsibility and informed choice, which has influenced academic, policy and government regulatory debate for over a decade (Hancock & Smith, 2017a). There is growing criticism of a responsible gambling model based on the notion of individual responsibility for harms, and a call for an approach based on consumer protection, public health, and operator duty of care (Abbott, 2020; Hancock & Smith, 2017a, 2017b; The Lancet, 2017). Indeed, The *Lancet Public Health* Commission on Gambling was recently established to thoroughly consider global issues concerning gambling, including the critical appraisal of regulatory, political, and public health responses (Wardle et al., 2021).

3.4.1. Limitations

This literature review has some limitations which should be considered when interpreting these findings. While the search terms were broad and formulated through discussion with the research supervisors and a research librarian, there may have been other useful terms not included which may have sourced additional articles. Additionally, despite conducting a wide-ranging systematic search, there is the possibility that some relevant articles were missed. A further limitation is that the quality of evidence included in the articles was not

considered. Therefore, the findings are not conclusive but may provide some insight into where the research has focused to date, and areas that require further research.

3.4.2. Conclusion

Despite the widely documented emphasis on venue staff to identify and respond to gamblers identified as having problems in situ, neither are staff inclined to approach them, nor gamblers to approach staff for assistance. The well documented psychological barriers to help-seeking as reviewed in Chapter 1 should be considered when considering engagement with patrons with potential gambling problems in land-based venues. Given the significant shame and embarrassment experienced by those afflicted, it could be reasonably argued that it is unrealistic to expect individuals with gambling problems to actively ask staff for help. While currently responsible gambling initiatives place an emphasis on gambling venues to identify and respond to gamblers suspected as having problems, there is little evidence-based information on how venue staff can best practically respond to identified gamblers to effectively facilitate harm reduction and help-seeking. Understanding the perspectives of venue staff and gamblers regarding identifying and responding to potential problem gambling behaviours in the venue, is a next logical step and Chapter 6 will present the first of two qualitative studies: an examination of the experiences of gambling venue staff who work in land-based gambling venues containing EGMs, and EGM gamblers. As described in Chapter 2, in addition to examining the experiences of gamblers and gambling venue staff, this thesis will explore the experiences of partners of non-help-seeking individuals with gambling problems. The following chapter will present a literature review of gambling-related harm as reported by CSOs.

CHAPTER 4. GAMBLING-RELATED HARM AS REPORTED BY CONCERNED SIGNIFICANT OTHERS: A SYSTEMATIC REVIEW AND NARRATIVE SYNTHESIS OF EMPIRICAL STUDIES

4.1. Introduction

As described in Chapter 2, the negative personal consequences of problem gambling are well documented. While there are numerous studies reporting on the impacts of problem gambling on families, a comprehensive picture of this research is lacking. The current chapter presents a systematic review and synthesis of the peer-reviewed literature from inception through to July 2018, related to the impacts of problem gambling on family and concerned friends. A systematic search strategy conducted through three electronic databases identified 47 studies that were appraised by two researchers independently. Following the extraction of data, a meta-synthesis was conducted. Findings from the 23 quantitative, 17 qualitative and 6 mixed-methods studies were arranged into four themes: impact on health; impact on the marital/couple dyad; impact on parents and children; and, help-seeking behaviour. The primary researcher noted an increase in attention by researchers on the impacts of gambling-related harm on CSOs during the past three years. Subsequently, a decision was made to adopt the same process used in this systematic review and perform the search from July 2018 to June 2021, and then synthesise and compare the new findings with those of the initial systematic review. The results of the updated review, which includes 28 additional studies, will be presented in section 4.6.

The adverse impact problem gambling can have on individuals afflicted is well documented (Dowling et al., 2014; Lorains et al., 2011; Neal et al., 2005) and has been described in Chapter 2. Though there is growing interest in examining the negative impacts of problem gambling more broadly (Langham et al., 2016; Shannon et al., 2017), the bulk of the literature regarding problem gambling has focused on individuals with the addiction, with

much less attention given to the impact it has on their families, including partners, children, parents, and other relatives.

Given the number of CSOs affected by an individual's gambling problem (Goodwin et al., 2017), this is surprising. The impact that substance-related addictive disorders such as excessive alcohol use, has on family life, is well documented (Hutchinson et al., 2014). In contrast, the impact of problem gambling on families has been given much less attention. Whilst there has been a growing interest in this topic over the past several years, there remains a lack of systematic reviews on gambling-related harm for CSOs.

A systematic review by Kourgiantakis, Saint-Jacques, and Tremblay (2013) examined studies related to problem gambling and families. The authors examined published and unpublished empirical studies written or published between 1998 and 2013. Studies that collected data from both CSOs and or gamblers were included. The purpose of their review was to examine the impact of problem gambling on families and the involvement of families in problem gambling treatment. Results of the review, based on 30 empirical studies, present the impact of gambling-related harm on partners and children, along with a focus on families' involvement in treatment. The main findings included a lack of understanding and awareness among partners as to the extent of the gambling problem and the negative impacts on the spousal relationship and relationships with extended family. Family involvement with treatment appeared to have a positive effect on the outcome.

While several studies involving gamblers with gambling problems have examined the impact on CSOs and family functioning from the perspective of the gambler, there is some evidence of a divergence in perspectives between gamblers and their partners. Gamblers perceive their family functioning and the impact of problem gambling on their family more positively than their partners (Cunha & Relvas, 2015; Cunha et al., 2015; Goodwin et al., 2017; Lorenz & Yaffee, 1988), and perceive neglect of their responsibilities as less problematic than

perceived by their partners (Li et al., 2017). A recent study investigating gambling-related experienced by affected others suggested that gamblers seemed unaware of the broader impacts of their gambling (Landon et al., 2018).

To properly understand the impact of problem gambling on CSOs, it is prudent, therefore, to examine data collected from the CSOs themselves. For this reason, the current systematic review is focused on published empirical studies that collected data directly from CSOs. Though there is some overlap with the Kourgiantakis et al. (2013) review, the distinction with the present review is a focus on gambling-related harm as reported by CSOs.

The spectrum of gambling participation

Gambling is defined as “to play a game for money or property” and to ‘bet on an uncertain outcome’ (Merriam-Webster, 2017). It is a particularly common behaviour in most parts of the world with rates of gambling participation during the previous 12 months ranging between 25% (Czech Republic) to 82% (USA). Problem gambling has been defined as “difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community” (Neal et al., 2005, p. 3). Researchers have found it useful to distinguish between sub-clinical and clinical levels of problem gambling to separate individuals who have severe gambling problems from those with moderate problems (Shaffer et al., 1999b). The *Diagnostic and Statistical Manual for Mental Health Disorders, Fifth Edition*, describes Gambling Disorder as “persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more)” symptoms as described by a checklist over 12 months (American Psychiatric Association, 2013, p. 587). Other researchers are of the view that gambling behaviour should be considered as a continuous variable, ranging from social or recreational gambling where there are no adverse impacts for the gambler or others arising from the gambling behaviour, through to problem gambling which arises when the gambling behaviour impacts adversely on the gambler and or others

(Neal et al., 2005). Individuals can experience problems at many points along this continuum (Tse et al., 2012).

4.2. Aims and objectives

The study presented in this chapter is focused on and aims to systematically review published peer-reviewed empirical studies from inception to July 2018, on the impact of problem gambling on CSOs, and to summarize the evidence on the impact on individual family members, friends, family life and family relationships. In addition, it aims to examine the efforts CSOs make in minimizing the harm caused by problem gambling including their attempts to encourage the gambler to seek help. Many studies on problem gambling and families have used clinical populations. Given only a small number of gamblers with gambling problems seek formal treatment (Productivity Commission, 2010; Volberg, 1997), this presents a sampling bias. In describing and synthesising the evidence in this review, a distinction is made between clinical and community populations.

The term significant other has been defined as “a person who is important to one’s well-being; especially: a spouse or one in a similar relationship” (Merriam-Webster.com, 2017b). In the problem gambling literature, the term concerned significant other has been commonly used to refer to any individual who has a relationship with a gambler with a problem. This comprises family members including partners/spouses, parents, children and extended family, as well as friends (for example, (Dowling et al., 2014; Makarchuk et al., 2002; Salonen et al., 2014; Svensson et al., 2013). For this review, the term CSO refers to any individual who has identified that they have a friend or family member with a gambling problem. For example, a Finnish population study identified CSOs by asking if any of the following: father, mother, sister/brother, grandparent, spouse, own child/children or close friend, had a gambling problem (Salonen et al., 2014).

Specifically, the aims of this current review are first, to describe the nature of existingpeer-reviewed published studies that have directly engaged CSOs concerning gambling-related harm, providing a distinction between clinical and non-clinical populations. Second, to improve our understanding of the degree and nature of the impacts of problem gambling on CSOs; how CSOs respond to gambling-related harm; identify gaps in the literature and provide specific directions for future research.

4.3. Methods of the review

The Preferred Reporting Items for Systematic reviews and Meta-Analyses Protocols (PRISMA-P) (Moher et al., 2015) were followed for the current review.

Search strategy and scope and inclusion criteria for studies in this systematic review

All study designs (e.g., cross-sectional, randomised control trial, qualitative interviews, population studies, observational studies) that collected data from CSOs directly were included in the review. The following databases were used for the systematic search: PubMed, Scopus and PsychInfo. In addition, reference lists of all included studies were searched manually. The structured search strategy was implemented on 27 June 2018 with the assistance of an academic librarian holding postgraduate qualification in information management. Given the limited literature in this area, the search included all studies from inception through to July 2018. The search terms used for each database are presented in Figure 2. Only empirical studies published in peer-reviewed journals in English were included. Studies were included if they contained data concerning the impact on, or experience of problem gambling on the gambler's family member/s. For the current review, a broad definition of problem gambling was used. The individual with the gambling problem was not required to be formally diagnosed with a gambling disorder. It was sufficient, for example, that the affected family member reported that their family member (whether it be partner, spouse, child or parent) had a gambling problem. Studies that did not collect data

directly from the gamblers' CSOs were excluded. For example, several studies have examined the gamblers' perspectives on their marital status, family and relationship functioning (Black et al., 2012; Ciarrocchi & Hohmann, 1989; Ciarrocchi & Reinert, 1993). Though such studies may provide some insight into the experiences of CSOs of gamblers with problems from the perspective of the gambler, they were not included in this review. Therefore, this review aims to produce a summary of the current state of knowledge of gambling-related harm from the perspective of CSOs.

Pubmed	gambl*[tw] AND (family*[tw] OR families[tw] OR familial[tw] OR parent*[tw] OR mother*[tw] OR father*[tw] OR child*[tw] OR grandparent*[tw] OR sibling*[tw] OR "concerned significant other*"[tw] OR partner*[tw] OR spous*[tw] OR wife[tw] OR wives[tw] OR husband*[tw] OR marital*[tw]) AND English[la]
Scopus	TITLE-ABS-KEY (gambl* AND (family* OR families OR familial OR parent* OR mother* OR father* OR child* OR grandparent* OR sibling* OR "concerned significant other*" OR partner* OR spous* OR wife OR wives OR husband* OR marital*)) AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re") OR LIMIT-TO (DOCTYPE , "ip"))
PsycINFO	(gambl* and (family* or families or familial or parent* or mother* or father* or child* or grandparent* or sibling* or "concerned significant other*" or partner* or spous* or wife or wives or husband* or marital*)).ti,ab,sh.

Fig. 2. Search terms used for systematic review
Notes. [tw] = search on title, abstract and Medical Subject Headings (MeSH) fields; TITLE-ABS-KEY = search on title, abstract and keywords fields; Ti = title; ab = abstract; sh=subject heading search

Assessment of methodological quality

All papers identified through the search process were assessed independently by two reviewers for methodological quality prior to inclusion in the review. Assessing the quality of published studies for inclusion in systematic reviews can be achieved by using either a components checklist or a scale that provides an aggregate score. There are a variety of instruments available designed to assess the quality of empirical studies. Such instruments

are not homogenous, with some including items more related to the quality of reporting, and others with more emphasis on the methodological quality of the study (Jüni et al., 1999). The use of a scale to produce an overall quality score is not well supported by empirical research, and the use of such scales is advised against by the Cochrane Collaboration (Higgins, 2006; Lundh & Gøtzsche, 2008). As such, the use of scoring to determine the quality of studies was not used for this review. Quantitative papers were assessed using the McMaster University Critical Review Form, Quantitative Studies Version (Law et al., 1998). Items included purpose and need for study, design, sample size, outcomes, details of the intervention, results, conclusions and implications. Qualitative papers were assessed using the McMaster University Critical Review Form, Qualitative Studies Version 2.0 (Letts et al., 2007). Items included purpose, need for study, qualitative design, theoretical or philosophical perspective, issues related to sampling and participant selection, methods for data collection, and the context of the study. Mixed study papers were assessed using the Mixed Methods Appraisal Tool Version 2011 (MMAT; Pluye et al., 2011). Items included objectives of study, sources of data, sampling strategies, the relevance of a mixed-methods design and integration of qualitative and quantitative data.

All papers were assessed independently by the two reviewers using the aforementioned instruments. The reviewers then met to compare and discuss the assessments until consensus was reached. There were no disagreements requiring consultation with a third reviewer. Methodological assessments were performed to report on the quality of studies and not used as a portal for inclusion of studies into the review.

Data synthesis

The findings of all included studies were synthesised following the Economic and Social Research Council's guidelines on narrative synthesis (Popay et al., 2006). Articles were uploaded into NVivo 11 qualitative data software tool to help organise the findings. An initial set of categories concerning the main findings across studies was then developed. These

categories were discussed by the review team until consensus was reached. Following this, the preliminary categories were then subjected to a meta-synthesis and re-grouped based on similarity and meaning. These themes and categories were then used to explore the patterns and relationships within and between studies to produce a comprehensive set of findings. Finally, the robustness of the synthesis was examined.

4.4. Results

Application of the search terms identified 4181 articles. These were then combined into an Endnote library for screening. Following the removal of duplicates, the inclusion criteria were applied to 3836 articles. Following the exclusion of 3613 articles, abstracts and/or full articles were examined for the remaining 223 articles and 171 were excluded. Among the remaining 52 articles, one study was found to have been reported twice in separate journals (Lorenz & Yaffee, 1988, 1989) and was therefore counted as one article. The reference lists of the remaining 51 manuscripts were then searched by hand (backward snowballing) which located a further 2 studies. This resulted in a final total of 53 studies for the review. The results of this process are presented in Figure 3.

Countries from which the greatest number of studies was conducted were Australia (16 studies; 30%), the USA (9 studies; 17%) and Canada (7 studies; 13%). Twenty-one (40%) of the studies involved quantitative, 26 (49%) qualitative and 6 (11%) mixed methods methodologies. Eighteen studies (34%) comprised CSO data drawn from clinical populations, (that is, where the gambler was receiving help or had completed a course of counselling and was in recovery). A further 34 studies (64%) did not report the help-seeking status of the gambler. One study (Patford, 2009) involved a deliberate effort not to rely solely on a clinical population, though did not report the help-seeking status of the gamblers.

Methodological quality

Overall, the included studies possessed a relatively high level of methodological rigour. The greatest issue among quantitative studies was the failure to report study dropouts. In addition, around a fifth of quantitative studies did not adequately describe the study sample. Among qualitative studies, around half did not identify a theoretical perspective, and although most studies detailed ethical clearance from a formal ethics committee, the vast majority did not report obtaining informed consent from participants. One third did not describe the purposeful selection process used in selecting study participants, and three fifths of qualitative studies did not identify potential influences, biases and assumptions of the researcher. Overall, a high level of rigour was observed in the reporting of qualitative data analyses including the provision of a decision trail. Likewise, for the mixed-methods studies, the majority did not address the researchers' potential influence. Furthermore, the majority of mixed-methods studies did not discuss the challenges and limitations of integrating qualitative and quantitative data. Some of these observations may be a product of the timespan of the studies, in that reporting requirements thirty years ago were somewhat different to today. Results of the methodological assessments are presented in Appendix 4.

Table 2. Themes and sub-themes

Themes	Sub-themes
Impact on CSOs' health (partners)	Mental health Risky alcohol and or other drug use) Physical health
Impact on the marital/couple dyad	Hypervigilance Conflict including familial violence Financial stress Comorbid alcohol and or drug use by the gambler
CSOs other than partners	Children Parents
CSOs help-seeking behaviour	Seeking help for themselves Seeking help for the gambling (including encouraging the gambler to seek treatment)

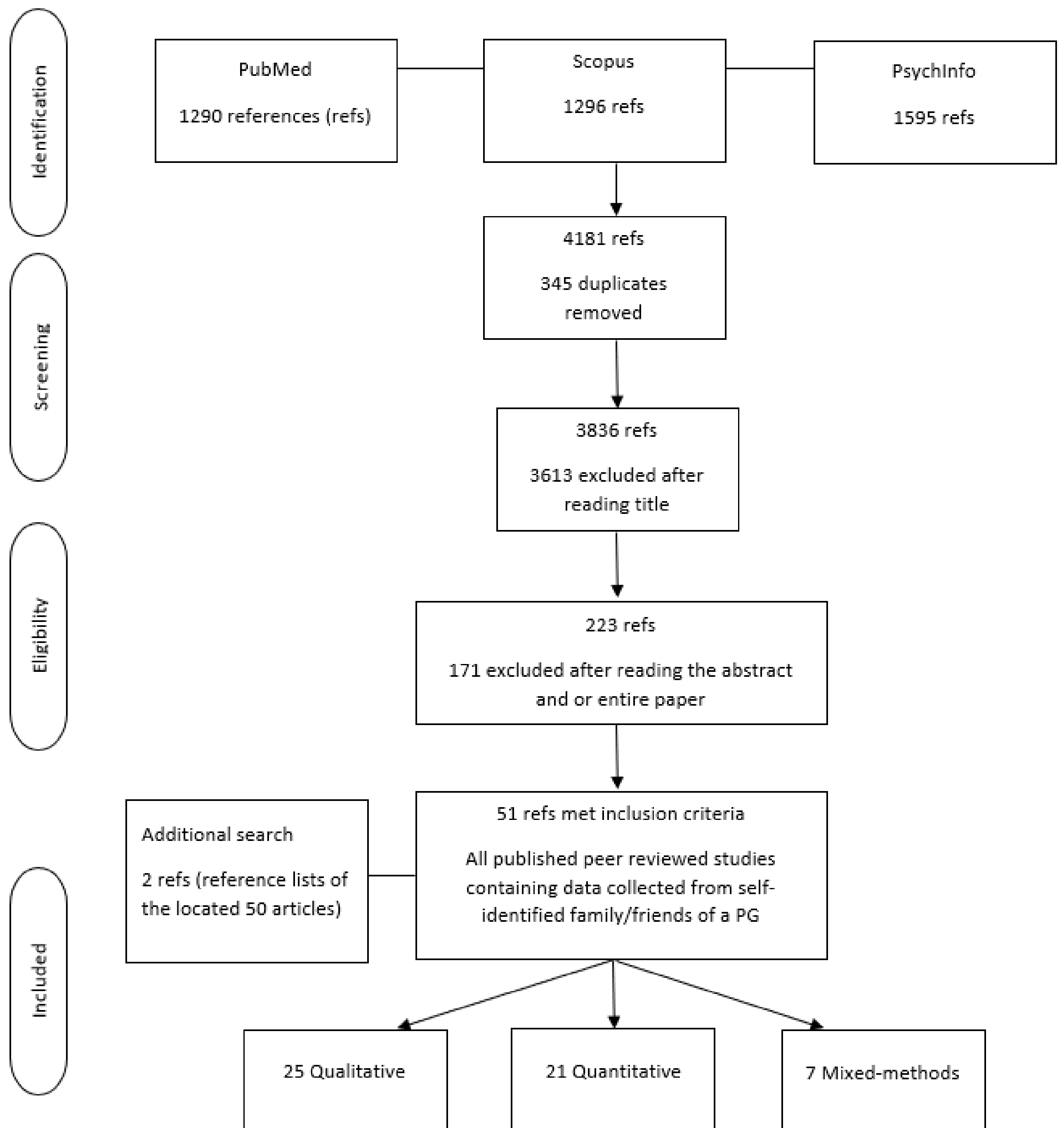

Figure 3. Flowchart of selection of articles according to PRISMA

4.4.1. Synthesised findings

The preliminary synthesis (Popay et al., 2006) resulted in 31 preliminary themes and 18 sub-themes which were collapsed into four themes and 11 sub-themes. Themes and sub-themes

for the meta-synthesis are presented in Table 2. These relate to impacts on CSOs' health, impacts on relationships with family members, and CSOs help-seeking behaviour.

Impact on CSO's mental health (partners)

A significantly higher prevalence of mood disorders has been reported among partners of individuals with gambling problems (Dannon et al., 2006; Goodwin et al., 2017; Rychtarik & McGillicuddy, 2006; Svensson et al., 2013; Wenzel et al., 2008) with psychological symptoms comparable to psychiatric inpatients (Makarchuk et al., 2002). Emotional distress was frequently reported (Chan et al., 2016; Dowling et al., 2009) and such experiences (stress, depression and anxiety) directly attributed to the partner's gambling problem (Holdsworth et al., 2013; Lorenz & Shuttlesworth, 1983). In some cases, the gambling increased following a deterioration in the partner's mental health, due to the gambler fearing they were losing their support (Boyd & Bolen, 1970), creating a vicious cycle. Personal distress was significantly and positively related to relationship distress (Hodgins, Shead, et al., 2007). Anger and depression were found to be the most commonly reported emotional problems reported by CSOs (Lorenz & Yaffee, 1989). Two studies, however, reported CSOs did not express greater signs of negative affectivity than non-CSO controls (Dowling et al., 2009; Mazzoleni et al., 2009). Around 13% of CSOs had experienced feeling suicidal (Lorenz & Yaffee, 1989) or attempted suicide with such attempts occurring following CSOs threatening separation or divorce actions (Lorenz & Shuttlesworth, 1983). Emotional distress was higher among CSOs who were living with as opposed to not living with the gambler (Makarchuk et al., 2002; Orford et al., 2017) and wives experienced greater distress than other family members (Orford et al., 2017).

CSOs' risky alcohol and/ or other drug use

Large population studies found that CSOs (including partners, friends, or other relatives) reported higher rates of smoking and risky alcohol use than for the general population (Salonen et al., 2015; Svensson et al., 2013). Partners reported engaging in dysfunctional

behaviours such as drinking, smoking, overeating and impulsive spending to help cope with the problem (Lorenz & Shuttlesworth, 1983). Gender differences were reported with male CSOs more likely to engage in risky drinking and females more likely to be daily smokers (Salonen et al., 2016; Salonen et al., 2014).

Impact on CSO's physical health (partners)

CSOs reported impaired physical health which they attributed directly to the gambling problem (Chan et al., 2016; Salonen et al., 2016; Wenzel et al., 2008). Female partners reported experiencing physical ailments during the worst of the gambling episodes. These included chronic or severe headaches, irritable bowel issues (Lorenz & Yaffee, 1988), stomach problems, feeling faint or dizzy, breathing irregularities, backaches, high blood pressure (Lorenz & Yaffee, 1989) and poor sleep (Landon et al., 2018; Li et al., 2017). Male partners also reported experiencing physical issues such as hypertension and feeling exhausted which affected their work (Patford, 2007a). A significant association was found between CSOs' physical illnesses and psychological difficulties, supporting the hypothesis that partners of CSOs experience physical disorders due to living under conditions of stress brought about by problem gambling (Lorenz & Yaffee, 1988). A large population study conducted in Finland reported being a CSO was significantly associated with poor health and wellbeing regardless of gender (Salonen et al., 2014).

Impact on the marital/couple dyad

Unsurprisingly, problem gambling had a substantial negative impact on couples' relationships (e.g., (Harrison & Donnelly, 1987; Landon et al., 2018). Gamblers, however, rated this impact of their gambling on their partner lower than the rating the partners gave, suggesting they tended to underestimate the negative effect of their gambling on their partners (Ferland et al., 2008). In some cases, interpersonal conflict was caused by the attempts the couples engaged to manage the problem, such as CSOs taking control of the finances, and constant monitoring for gambling behaviour. A recent study examining

gambling-related harm on affected others found neglect of responsibilities was the most severe relationship harm (Li et al., 2017). CSOs often described their gambling partners as ‘childlike’ (Dickson-Swift et al., 2005). Interpersonal conflict was frequently reported among both male and female CSOs (Crisp et al., 2001) with threats of separation or divorce common (Lorenz & Shuttlesworth, 1983). Deciding whether to leave or stay in the relationship was a significant issue for some female partners who described that the consideration of leaving was accompanied by substantial fears about what the future held (Borch, 2012; Patford, 2009).

Hypervigilance

A common experience reported by CSOs was a chronic enhanced state of anxiety attributed to fear that the partner might be gambling or about to gamble (Heineman, 1987; Holdsworth et al., 2013; Krishnan & Orford, 2002). This led to CSOs continuously seeking evidence of gambling, such as checking bank statements or searching clothing for betting slips (Krishnan & Orford, 2002; Patford, 2009). Female CSOs expressed difficulty in detecting gambling behaviour, commenting that it was not as easy as detecting drinking (Heineman, 1987). Therefore, they continued to worry that the amount of debt was greater than what they were led to believe: “the wives of the gamblers had no reliable barometer for detection; thus, their anxiety appeared greater” (Heineman, 1987, p. 34). Such monitoring behaviours were reported to have harmed the relationship in that they made the gambler defensive and resentful (Patford, 2007a). Feelings of resentment were likewise experienced by CSOs for feeling they were going without even basic necessities due to lack of finances (Dickson-Swift et al., 2005). Hypervigilance was also related to CSOs receiving and fearing contact from creditors (Mathews & Volberg, 2013), fearing the gambler may lose his or her job, and worry about the gambler’s depression, mood swings, physical health and unhealthy appearance (Krishnan & Orford, 2002). A population study reported all self-identified CSOs had indicated they had provided the gambler with money they believed would be used to either gamble or pay gambling-related debts (Svensson et al., 2013). Such enabling behaviour was explained

by some CSOs by their fear that the gambler would resort to criminal activity to obtain money (Krishnan & Orford, 2002). Some CSOs reported being frightened to answer the door for fear it might be the police (Dickson-Swift et al., 2005). Partners described feeling terrified by the uncertainty that had entered their lives (Holdsworth et al., 2013).

Conflict including familial violence

Familial violence was not an uncommon experience among CSOs. Almost 80% of women attending a forensic medical clinic in Turkey reported their male partner had a gambling problem, and more than a third attributed the reason for the assault, which prompted their attendance at the clinic, to the gambling problem (Balici & Ayranci, 2005). Having a partner with a gambling problem increased the odds of experiencing familial violence among women attending an emergency department in the United States (Muelleman et al., 2002). Female CSOs in a recent New Zealand study described verbal and physical abuse following arguments about their partners' gambling (Landon et al., 2018). A population study in Finland found that CSOs were significantly more likely to report being subjected to domestic violence during the previous 12 months compared to non-CSOs (Svensson et al., 2013). A large study across Australia and Hong Kong reported more than half of CSOs indicated some form of familial violence during the previous 12 months, with females more likely to report victimization than males (Suomi et al., 2013). A New Zealand study, however, found that the relationship between familial violence and PG became insignificant after controlling for alcohol use (Schluter et al., 2008).

Financial distress

Most CSOs experienced financial difficulties (Landon et al., 2018; Lorenz & Shuttlesworth, 1983) with more female CSOs indicating financial stress than males (Crisp et al., 2001). Gambling-related debts appeared to be the most common source of financial stress (Holdsworth et al., 2013; Krishnan & Orford, 2002; Lesieur, 1979; Mathews & Volberg, 2013; Valentine & Hughes, 2010) resulting in some CSOs returning to work or working extra hours

to help with the repayments (Holdsworth et al., 2013; Krishnan & Orford, 2002; Mathews & Volberg, 2013). In some cases, the financial problems were such that CSOs resorted to borrowing money to support basic needs (Lorenz & Shuttlesworth, 1983) or families having to sell their home (Mathews & Volberg, 2013). Financial harms continued to impact families even when the gambler ceased gambling (Langham et al., 2016).

CSOs other than partners

Children

Children of parents with gambling problems were more likely to exhibit problem gambling behaviours themselves (Jacobs et al., 1989; Vachon et al., 2004) and reported higher levels of alcohol and tobacco use and a greater preference for stimulant drugs than children of parents without gambling problems (Jacobs et al., 1989). Some adult children, however, reported that being exposed to heavy gambling as a child, made them less likely to gamble (Landon et al., 2018). Children of parents with a gambling problem reported almost twice the incidence of parental separation or death of a parent, twice the rate of use of prescription antidepressants and twice the amount of suicide attempts than children of parents without gambling problems (Jacobs et al., 1989). Difficulties at school were also reported among children of parents with gambling problems, such as behavioural or adjustment problems and running away from school or home (Lorenz & Shuttlesworth, 1983). A common form of neglect involved children being left unattended while the parent gambled (Landon et al., 2018; Li et al., 2017).

Children with a parent who had a gambling problem along with a co-morbid alcohol, drug or over-eating problem, reported greater problems than children with a parent a gambling problem only (Leiseur & Rothschild, 1989). Where the parent with a gambling problem had acknowledged their problem and sought help, children scored better overall on psychological measures than families of non-help-seeking gamblers with problems (Leiseur & Rothschild, 1989). Gamblers neglected to spend time with their family due to gambling (Langham et al.,

2016). Partners of gamblers with problems reported they did not feel the gambler spent enough time with their children (Lorenz & Yaffee, 1988). Children reported they could sense the tension in the family home (Darbyshire et al., 2001; Patford, 2009). Concern for the aversive manner the gambler treated their grandchildren was reported by adult children (Landon et al., 2018). Older children also indicated they were less affected as they were financially independent (Patford, 2009), though adult children indicated they distanced themselves from their gambling parents due to fear that if they showed warmth they would be harassed for money (Mathews & Volberg, 2013). Adult children described how taking control of their parents' financial affairs had led to them perceiving themselves as their parents' caregiver (Langham et al., 2016; Patford, 2007b), while younger children were reported to take on household chores and stay home from school as a result of their parents' gambling (Langham et al., 2016).

Such distancing for fear of being harassed for money was reported also by more extended family members (Mathews & Volberg, 2013). In one study, 79% of children complained about the impact of problem gambling on the family finances whereas only 36% of the gambling parents reported their gambling had a negative financial effect on their children (Wurtzburg & Tan, 2011). Gamblers, therefore, tended to underestimate the negative impact that their gambling had on both their partners (Ferland et al., 2008) and their children (Wurtzburg & Tan, 2011). Some children indicated being physically abused by their gambling parent (Ferland et al., 2008) or grandparent (Landon et al. 2018). Children found it difficult to discuss difficulties associated with having a parent with a gambling problem, with a third of children reporting they had never spoken about it with anyone outside the family home (Wurtzburg & Tan, 2011). Furthermore, parents were unaware of the difficulties their children experienced in discussing the negative effects of parental problem gambling. One reason for children's reluctance was that they wanted to be perceived as normal (Wurtzburg & Tan, 2011).

Parents

Only one study focused on the effects of adult children's gambling on parents andparents-in-law (Patford, 2007c). Patford's study (2007c) revealed such parents experienced diminished enjoyment in life and increased physical and emotional stress along with financial problems. The gambling also placed pressure on the parent's relationship with their partners as they negotiated the best way to manage the situation. A recent qualitative study by Landon et al. (2018) described conflict between a parent and their adult child who had a gambling problem concerning the gambler's ill-treatment of their children. The breakdown of the relationship between adult gamblers and their parents impacting on grandchildren was also reported by Langham et al. (2016).

CSOs seeking help for themselves

Given the enormous impacts of problem gambling on CSOs, it is not surprising that many seek help for themselves. Three decades ago, Heineman (1987) made the comment that treatment for wives of men with alcohol problems had been available for over three decades but treatment for wives of men with gambling problems was almost non-existent. The majority of CSOs pursued help for themselves firstly, through self-management strategies such as talking to the gambler about how the problem was affecting them and organising direct debit arrangements for household bills (Hing, Tiyce, et al., 2013). In addition to self-coping, CSOs sought help from a range of sources including doctors, solicitors, bank employees and clergymen (Krishnan & Orford, 2002; Lorenz & Shuttlesworth, 1983) as well as family members and friends (Hing, Tiyce, et al., 2013; Patford, 2009) and specialist gambling help services (Goh et al., 2016; Patford, 2009). When approaching relatives or friends, CSOs were careful about how much and what they disclosed, fearing they might lose friends (Kourgiantakis et al., 2013; Patford, 2009). Though many CSOs sought help, others described a reluctance to do so unless motivated by their children (Landon et al., 2018).

Attempts by CSOs to encourage the gambler to seek help

CSOs have a high awareness of gambling problems in the family and therefore offer a potentially useful pathway to help motivate gamblers with problems to seek help (Wenzel et al., 2008; Kourgiantakis et al., 2013). Many CSOs had made attempts to encourage the gambler to seek help (Hing, Tiyce, et al., 2013; Patford, 2009; Patford, 2007a, 2007c) employing a variety of strategies to encourage help-seeking and reduce their gambling. In some instances, family members 'forced' the gambler to attend Gamblers Anonymous (Krishnan & Orford, 2002).

Attempts to challenge the gamblers' erroneous gambling-related beliefs were reported by some CSOs (Patford, 2007a, 2009). Other strategies included changing passwords for accounts, planning incompatible activities such as family outings (Valentine & Hughes, 2010), closing joint bank accounts (Patford, 2007a) and encouraging the gambler to talk to others about the problem (Krishnan & Orford, 2002).

4.5. Discussion

This review aimed firstly, to describe the nature of existing peer-reviewed published studies from inception through to July 2018 which directly engaged CSOs concerning gambling-related harm. Secondly, to synthesise this literature and describe the impacts of problem gambling on CSOs; how CSOs respond to gambling-related harm, including their attempts to encourage the gambler to seek help; identify gaps in the literature, and provide specific directions for future research. The studies were published between 1979 and 2016. During the search and inclusion process, 53 studies were found that addressed this study's aims. Analysis of the 53 studies resulted in four meta-synthesised findings. These meta-syntheses address the impact of problem gambling on partners' health, the spousal relationship, impact on CSOs other than partners, and the help-seeking behaviours of CSO's.

The first synthesised finding concerned the impact of problem gambling on partners' mental and physical health. Partners experienced significant emotional distress such as depression, anxiety, anger and suicidal ideation, and elevated rates of risky alcohol use and smoking. Partners also reported impaired physical health such as headaches, backaches, and hypertension.

The second synthesised finding concerned the impact of problem gambling on the spousal relationship. Substantial negative impacts were reported such as interpersonal conflict. Divorce and separation were common, as were high levels of domestic violence. Chronic hypervigilance was a common experience by partners, as they perpetually searched for evidence of gambling behaviour.

The third synthesised finding related to the impact of problem gambling on children, parents, and extended family. Children displayed higher levels of risky behaviours and mental health concerns including suicide attempts and reported high incidents of parental separation. They were reluctant to disclose their emotional problems to their gambling parent or anyone outside the family home. The impact of parental problem gambling on older children was quite different. Older children were less affected due to greater financial independence, and adult children distanced themselves from their gambling parents to avoid being harassed for money. The fourth synthesised finding concerned help-seeking behaviour by CSOs. The majority of CSOs had sought help through self-coping strategies which commonly involved taking over the family's finances. They also sought help from a range of professionals and specialist gambling services. They were reluctant to disclose details of the gambling problem to their friends. With respect to CSOs attempts to encourage the gamblers to seek treatment, there was very little literature that addressed this. The available data suggested many CSOs had made such attempts, which included coercing them to attend problem gambling support groups, challenging their gambling-related beliefs, and encouraging them to speak to others about their problem.

Studies included in this review contained data collected directly from family and friends themselves, as opposed to data relating to the gamblers' perspectives on their social and family functioning. This is an important distinction, as reported in this review, studies that have compared the perspectives of gamblers and their CSOs concerning the impacts of problem gambling, suggest an apparent divergence. Gamblers appeared to underestimate the negative impact of their gambling on their partners (Cunha & Relvas, 2015; Cunha et al., 2015; Ferland et al., 2008; Lorenz & Yaffee, 1989).

A third of studies reviewed involved CSOs who were associated with a gambler receiving help, while the majority of studies did not report the help-seeking status of the gambler. Just three studies (Hodgins, Toneatto, et al., 2007; Makarchuk et al., 2002; Nayoski & Hodgins, 2016) deliberately recruited CSOs associated with gamblers with a problem who were not receiving help. There was some evidence that family functioning improves when the gambler enters treatment (Boyd & Bolen, 1970; Lee & Rovers, 2008) and that children of parents with gambling problems receiving help are psychologically healthier than children of parents with a gambling problem who are not receiving help (Leiseur & Rothschild, 1989). To improve our understanding of the impacts and experiences of CSOs associated with non-help-seeking gamblers with problems, more research carefully targeting such CSOs, is needed (e.g., (Bond et al., 2016).

The themes and sub-themes in the present study were generated inductively, synthesising the findings across all 51 studies, as opposed to beginning with a prior set of potential harms. Through this process, the main themes were arranged according to the focus and findings of the selected studies. While more recently, research on gambling harm and affected others has taken a broader approach, examining the types of harm across all CSOs (e.g., Li et al., 2017; Shannon et al., 2017), the bulk of research to date has focused on a particular group such as partners (e.g. Lorenz & Yaffee, 1989; Mazzoleni et al., 2009; Schluter et al., 2008) or children (e.g. Leiseur & Rothschild, 1989; Wurtzburg & Tan, 2011).

The results of this review provide us with a sense of where the research to date has been conducted with CSOs. For example, much more research concerning gambling-related harm has been conducted with partners (more than two-thirds of studies) than other CSOs. Future research could consider whether being a friend, child, parent, or partner has any impact on how potential harm is experienced, and the type of support that would be most beneficial.

The types of harm reported across studies from the present review (mental health, risky alcohol/other drug use, physical health, marital conflict/familial violence and financial stress) are largely consistent with categories reported by recent research which has aimed to quantify gambling harm. Shannon et al. (2017) reported seven domains of harm: health, social, critical events, social, employment, finance and psychological. Interestingly, leisure (withdrawal of leisure activities by CSOs) was among their top five weighted harms yet did not arise as a gambling harm sub-theme in our synthesis. This suggests that though this particular harm is important, there is very little research in this area. Similarly, employment did not emerge from our synthesis. Employment was a domain also derived from the Li et al. study (2017) which presented six domains of harm (financial, work/study, health, emotional/psychological, relationships and other). That this harm did not emerge from the current synthesis, suggests that affected others' reduced performance and or related absence from work/study, is also an area lacking in research.

4.5.1. Limitations

This review has several limitations. First, only peer-reviewed studies written in English were included. Information from books, conferences, unpublished work or grey literature was not included. As such, there may have been relevant studies in the grey literature which were not included, such as reports by Gambling Research Australia. One such study is Dowling et al.'s (2010) research that found children raised in families exposed to problem gambling, were vulnerable to developing gambling problems. Though that particular study was not

included in our review, the issue was picked up in Jacobs' et al. (1989) study. Second, only a small number of studies reported recruiting CSOs associated with non-treatment-seeking gamblers with problems, which potentially presents a sampling bias. A third limitation concerns the lack of attention to researchers' possible influences and biases among the qualitative studies. A fourth limitation concerns a response bias among most studies, in that the vast majority involved samples containing substantially higher proportions of female CSOs. Finally, despite conducting a wide-ranging systematic search, there is always the chance that some pertinent studies may have been overlooked. One study that meets the inclusion criteria set out for this review and was not picked up in the systematic search strategy, was brought to the lead researcher's attention by an examiner of this thesis. Holdswoth et al. (2013) interviewed 11 family members of Indigenous Australians who gamble regularly. The results revealed substantial barriers are faced by Indigenous Australians in accessing formal gambling help services and accessing informal help from family and friends is more common. While seeking help from family was considered a protective factor for Indigenous gamblers, family may not members may not know how to best assist a relative with a gambling problem (Holdsworth et al., 2013). These limitations should be taken into account when interpreting the results of this review.

4.5.2. Conclusion

Notwithstanding the stated limitations, this systematic review provides comprehensive coverage of the empirical literature on gambling-related harm and affected others. It is clear that the impact of problem gambling is widespread and has significant negative effects on partners, children, and parents. Partners are especially impacted, suffering both mental and physical health problems. Children are also particularly affected and appear to suffer silently due to their reluctance to disclose their parental problem gambling worries. Problem gambling treatment and counselling services should take into account the pervasiveness of the impacts of problem gambling and be equipped to respond appropriately to the needs of

CSOs. Due to the response biases that emerged through reviewing this literature, future research should focus on male CSOs and CSOs associated with individuals with gambling problems who are not seeking help. Focused research on CSOs' withdrawal from leisure activities and the impact on work/study is also needed.

4.6. Gambling-related harm as reported by concerned significant others: an update of the literature

The initial search for the systematic literature review presented in this chapter was conducted on 27th June 2018. The following section will present an updated review of this literature employing the same search strategy and inclusion criteria. The updated search was conducted on the 16th of June 2021 with the assistance of a research librarian. To recap, articles were included if they were empirical studies published in peer-reviewed journals in the English language and contained data collected data from CSOs directly, concerning the impact on, or experience of problem gambling on the gambler's family member/s. All study designs (e.g., cross-sectional, randomised control trial, qualitative interviews, population studies, observational studies) were included. In addition, backward snowballing was performed by searching the reference lists of all included studies.

Assessment of methodological quality

All papers identified through the updated search process were assessed for methodological quality using the same tools: quantitative papers were assessed using the McMaster University Critical Review Form, Quantitative Studies Version (Law et al., 1998), qualitative papers were assessed using the McMaster University Critical Review Form, Qualitative Studies Version 2.0 (Letts et al., 2007), and mixed study papers were assessed using the Mixed Methods Appraisal Tool Version 2011 (MMAT; Pluye et al., 2011). Methodological assessments were performed to report on the quality of studies and were not used to determine inclusion in the review.

Data synthesis

The findings of all included studies were synthesised following the Economic and Social Research Council's guidelines on narrative synthesis (Popay et al., 2006). Articles were uploaded into NVivo 11 qualitative data software tool to help organise the findings. The main findings were then considered against the inductively developed a priori themes and categories that emerged from the original literature review.

4.6.1. Results

Application of the search terms identified 1292 articles. These were then combined into an Endnote library for screening. Following the removal of duplicates, the inclusion criteria were applied to 691 articles. Following the exclusion of 650 articles by reading titles and or abstracts 41 articles were examined by reading their full text. Snowballing was then performed with the 28 articles which involved searching the reference lists by hand. This process did not identify any further articles for inclusion. One potential article by Tulloch et al. (2020) which examined the impact of gambling-related harm on family functioning was identified through the snowballing process, however, a full-text examination revealed that while the study did collect data from CSOs directly, the reporting of the CSO and gambler data was aggregated, and therefore excluded from this review. This resulted in a final total of 28 studies for the updated review. The results of this process are presented in Figure 4. Australia and Canada produced the most studies (5 and 4 respectively) with a relatively even spread of studies among the remaining 13 countries. Fifteen (53%) of the studies involved quantitative, 10 (36%) qualitative and 3 (11%) mixed methods methodologies. Ten studies (36%) comprised CSO data drawn from clinical populations, (that is, where the gambler was receiving help or had completed a course of counselling and was in recovery). A further 17 studies (61%) did not report the help-seeking status of the gambler. One study which evaluated the effectiveness of internet-delivered therapy for CSOs (Magnusson et al.,

2019a), collected data from CSOs of treatment refusing individuals with gambling problems. Characteristics of the studies are presented in Appendix 1.

Methodological quality

Overall, the included studies possessed a high level of methodological rigour. As was found in the earlier review, among qualitative studies, half did not identify a theoretical perspective and two-thirds did not identify potential influences, biases, and assumptions of the researcher. Results of the methodological assessments are presented in Appendix 2.

Synthesised findings

The earlier review observed that approximately half of the studies (53%) focused specifically on partners of individuals with gambling problems with around a third (33%) involving a combination of other CSOs (e.g., other relatives and friends). The results of the updated search followed a similar trend with around half (48%) of studies involving CSOs who were partners and around a third (37%) a combination of partners and other family members or friends. The findings from the 28 recent studies fit appropriately into the four a priori themes developed from the earlier review. These related to impacts on CSOs' health, impacts on relationships with family members, and CSOs help-seeking behaviour. One additional sub-theme emerged under the category of impact on CSO's health (partners), concerning the isolation experienced by partners through their efforts to conceal the problem. There was no new information among the updated studies for the two sub-themes under this category: risky alcohol and or other drug use, and physical health. The themes that contained the most data across the updated studies were CSOs seeking help for themselves, and interpersonal conflict including intimate partner violence.

Impact on CSO's mental health (partners)

A recent study by Estevez et al. (2020) examined coping and dysfunctional psychological symptoms among family members of individuals with gambling disorders. Partners along

with other family members (siblings, children and parents) of individuals with gambling problems scored higher on measures of anxiety, depression, and difficulties in emotion regulation (Estevez et al., 2020). Jefferey et al. (2019) compared gambling-related harms between gamblers and their spouses across six domains of gambling harm: financial, relationship, emotional/psychological, health, work/study, and social deviance. Spouses reported the highest number of harms within the emotional/psychological domains, while gamblers reported a higher number of harms across all other domains.

Other studies that examined the impact of problem gambling on intimate partners, described considerable psychological distress among them, such as clinically significant anxiety and depression (Petra, 2020) and a range of other affective distresses such as shock, sadness, grief, anger, and shame (Kwan et al., 2020). Shame and stigma were described not only by gamblers but also by their partners and appeared to be related to two issues: having a partner who was a gambler and choosing to stay with the partner despite the gambling problem (Klevan et al., 2019).

An additional sub-theme, loneliness, emerged under this category. Living with a partner with a gambling problem was described as a lonely project across several dimensions such as: experiencing the “lone problem”, being the “lone parent”, and the “lone adult” (Klevan et al., 2019, p. 98). Findings from Klevan et al.’s (2019) study suggested loneliness resulted from a general lack of knowledge and recognition of gambling as a problem. As noted by Landon et al. (2018), gambling harms, particularly concerning CSOs, largely remain hidden. Another study examining coping strategies among partners of individuals with a gambling disorder found that withdrawal was a frequently reported strategy and considered by partners to be particularly helpful. While withdrawal coping; disengaging with the gambling partner and focusing on oneself, may help to preserve their own wellbeing and was reported by CSOs to be helpful, partners of individuals with gambling problems reported lower levels of companionship than partners of gamblers without gambling problems (Ponti et al., 2019).

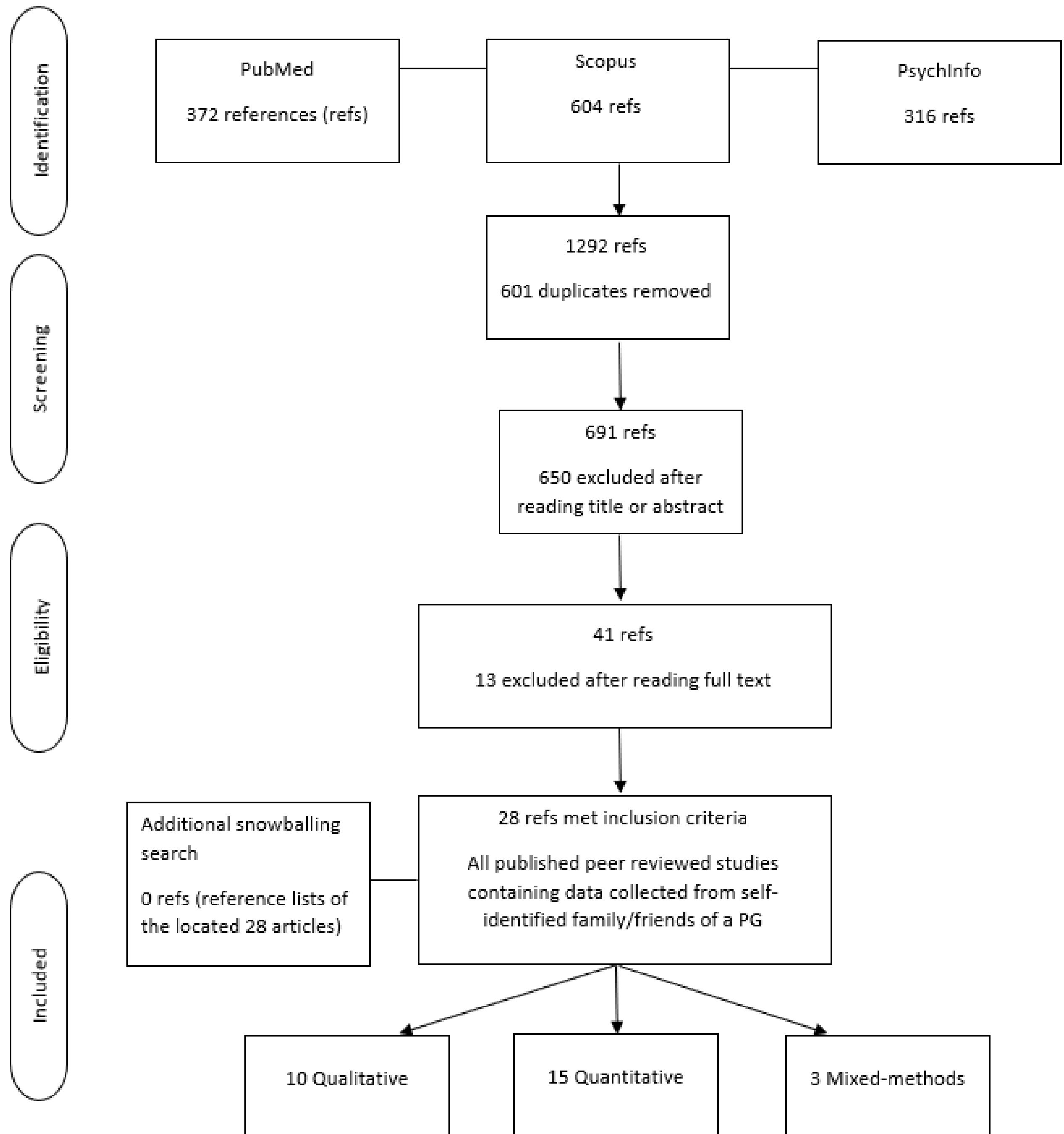

Figure 4. Flowchart of selection of articles according to PRISMA.

Loneliness can be considered an emotional state and therefore fit within the existing sub-theme of mental health; however, it was decided to create a distinct sub-theme. Loneliness experienced by partners appeared to be largely related to stigma. Partners tended to use withdrawal coping in their attempts to protect themselves and the gambler from social

stigma, and such coping strategies may, although initially be helpful, lead to and maintain additional emotional problems.

Impact on the marital/couple dyad

Ponti et al. (2019) compared the quality of romantic relationships between couples where one partner had a gambling problem, and those without. Problem gambling couples, both the gambler and their partner, reported a worse quality of relationship than non-problem gambling couples, and this was especially stronger for the partners of gamblers. Partners of individuals with gambling problems reported a worse quality of couple relationships on all dimensions investigated (Ponti et al., 2019). Gamblers concealing their gambling and secretly draining financial resources were behaviours reported by partners that destroyed trust in their relationship (Cote et al., 2020). Interpersonal relationship difficulties among problem gambling couples were further complicated by the non-gambling partners' preferred coping strategy. A study investigating coping strategies used by partners of individuals with a gambling disorder reported that withdrawal coping was the most helpful among participants (Petra, 2019).

Hypervigilance

Two studies described chronic hypervigilance among partners of individuals with gambling problems. Partners reported not being able to trust the gambler after they lied so many times, and the loss of trust led to increased anxiety (Järvinen-Tassopoulos, 2020), while another study reported the partner becoming increasingly vigilant about the household finances once they were made aware of the gambling problem (McKeown et al., 2020).

Conflict including familial violence

The loss of trust experienced by partners was reported to lead to increased anxiety about gambling behaviour which led to increased arguing about gambling (Järvinen-Tassopoulos,

2020), and problem gambling couples were more likely to report interpersonal conflict than their non-problem gambling counterparts (Ponti et al., 2019). Furthermore, compared to gamblers, partners were five to six times more likely to report increased conflict in their relationship due to gambling than their gambling partners (Jeffrey et al., 2019). Intimate partner violence was reported widely across studies (Kourgiantakis et al., 2018; Park & Park, 2019; Ponti et al., 2019) both physical and or emotional (Kwan et al., 2020) and physical and or verbal abuse (Landon et al., 2018). A New Zealand study reported two-thirds of affected others reported being a victim of interpersonal violence and more than half reported perpetrating violence (Palmer du Preez et al., 2018). The most common form of violence reported in the Palmer du Preez et al. (2018) study was emotional and verbal abuse.

Financial distress

Financial distress was reported among partners and other family members as having a serious impact on their standard of living (Fulton, 2019; Klevan et al., 2019), along with anxieties about their future (Klevan et al., 2019). Through investigating the impacts of gambling harm on female spouses in Hong Kong, Kwan et al. (2020) observed three main types of financial loss: lack of financial support (household money) from the individual with a gambling problem, recurrent financial loss due to new debts incurred by the gambler's relapses into problem gambling, and drain on financial resources in bailing out the gambler. Financial distress through bailing out gamblers was also reported by other family members in a study by Magnusson et al. (2019b), where two-thirds of CSOs reported having lent money to the gambler.

CSOs other than partners

Children: The findings among the more recent studies concurred with the results from the earlier review in that children were reported to be particularly affected by harms associated with problem gambling: having a parent or sibling with a gambling problem significantly increased the risk of developing a gambling problem (Afifi et al., 2020; Dowling et al., 2018;

Dowling et al., 2021; Forrest & McHale, 2021), and children raised in families with problem gambling were more likely to report parental separation and divorce (Dowling et al., 2021). Interestingly, adults with a gambling problem who reported growing up with a problem gambling father were equally likely to be male and female, while those reporting maternal problem gambling were most likely to be female (Dowling et al., 2021). These findings were in contrast to a study by Forest and McHale (2021) who found that problem gambling by parents was a predictor of offspring problem gambling, but only cross-gender (fathers' behaviour influencing daughters and mothers' behaviour influencing sons). Concerned significant others expressed concerns about the welfare of their children due to problem gambling-related harm (Landon et al., 2018), including being physically abused by the gambler (Kwan et al., 2020).

CSOs seeking help for themselves

A large proportion of gambling-related harm remains hidden and help-seeking rates among CSOs continue to be relatively low (Landon et al., 2018), largely due to stigma experienced by CSOs (Järvinen-Tassopoulos, 2020), for example, families keeping the problem secret to limit the social impact (Fulton, 2019). A German study by Buchner et al. (2019) examined if an internet-based support program was a viable way of supporting affected others of disordered gamblers. Their results suggested that e-health can overcome some of the barriers hindering CSOs in accessing help and is potentially a viable way of reaching and supporting affected others. In their study, the most affected others were partners (73%) or parents (13.5%) of individuals with gambling problems. Of note, most CSOs (over 90%) were female, consistent with the trend among CSO studies reported in the earlier review. Another study that examined the use of internet-delivered support for CSOs was conducted by Nilsson et al. (2020) who conducted a randomised control trial involving individuals with gambling problems and their partners. The study compared couples therapy with individual therapy, both internet-based treatments. There was no difference between the two

interventions among the gamblers, however, partners receiving couples therapy reported better outcomes on depression and anxiety than partners receiving individual therapy.

Attempts by CSOs to encourage the gambler to seek help

Rodda et al. (2019) investigated the needs of help-seeking CSOs. Along with support for their own wellbeing, CSOs indicated a desire for assistance in encouraging the gambler to both reduce gambling and engage in treatment. Half of the participants requested advice or support in getting the gambler to reduce their gambling and seek help. Some CSOs were very clear that they did not require support for their own wellbeing, rather, they wanted advice and guidance on how to help the gambler to address their problem. Rodda et al. (2019) concluded that interventions for CSOs should address both how the CSO can help the gambler, and support for their own wellbeing.

A qualitative study by Cote et al. (2018) investigated coping strategies among partners of individuals with gambling problems. Many of the coping strategies reported, focused on the gambler, such as encouraging them to; seek help, avoid risky situations, and understand the full extent of the impact of gambling-related harm on the family. These findings are consistent with Rodda et al's. (2019) study that highlighted the desire for CSOs for support and advice which focused on how they can help the gambler, rather than solely on their own wellbeing. The findings by Cote et al. (2018) also indicate CSOs felt the gambler did not fully appreciate the impact of their excessive gambling on their family, nor the efforts made by CSOs to detect their gambling and minimise the harm.

Another study by Cote et al. (2020) reported that gamblers found it difficult to show empathy for their partner's suffering and appeared to deny the severity of the gambling harms experienced by their partner. Similarly, Landon et al. (2018) reported that CSOs noted how the gamblers seemed less affected than themselves and unaware of the broader impacts of

their gambling, and gamblers did not always realise the effect of their gambling on their partners in a study by Tremblay et al. (2018). Of interest, the findings of a study by Magnusson (2019b) seem to, in part, contradict the gap in perception between CSOs and gamblers about gambling hams found by other studies. The authors examined the level of agreement between CSOs and those with gambling problems concerning the amount of money lost. Overall, they found a fair level of agreement between gamblers and their CSOs, with partner CSOs exhibiting better agreement than parent CSOs regarding the amount of money lost (Magnusson et al., 2019b).

4.6.2. Discussion

This updated review aimed to describe the nature of peer-reviewed published studies between July 2018 to June 2021 which directly engaged CSOs concerning gambling-related harm and to synthesise the updated literature with the findings of the previous systematic review. In the original review, 47 studies were included which spanned 39 years (1979 to 2018). Using the same search terms and inclusion criteria, this updated review included 27 articles published in the three years since the first review. This reflects a substantial increase in research activity and interest in the effects of gambling-related harm on CSOs during the past three years. As with the original review, this updated review was limited to articles published in peer-reviewed journals. Therefore, there may have been relevant studies published in the grey literature that were omitted. One such report is a qualitative study by Hing, O'Mullen et al. (2020) that included interviews with 48 women with lived experience of intimate partner violence related to a partner's gambling problem. The findings indicated that problem gambling intensified violence towards women.

Overall, the results of this updated review are consistent with those of the earlier review. The synthesised findings of the 27 recent studies were able to be appropriately incorporated with the a priori categories and sub-themes developed from the earlier systematic review, with

one additional sub-theme emerging, loneliness. Partners experienced significant psychological distress. There were no further data concerning their physical health or use of alcohol and other substances. The vast majority of CSOs in the recent articles were female, a trend also reported in the earlier review. Similarly, most studies involved CSOs in populations where the gambler was receiving help, or their help-seeking status was not reported. Just one study specifically recruited CSOs of non-treatment seeking individuals with a gambling problem.

Consistent with the findings of the earlier review, children were particularly affected by problem gambling. The evidence continues to grow concerning an association between those with gambling problems and problem gambling among their offspring. Regarding CSOs seeking help for themselves, help-seeking rates are low and there is emerging evidence that e-health platforms may be potentially effective in engaging this group. Further, recent research indicates CSOs desire support that focuses on advice to support the gambler and encourage them to seek help, rather than focusing only on their own wellbeing. Finally, recent research confirms previous findings of a significant discrepancy between individuals with gambling problems and their CSOs concerning the impact of the problem. The findings of this updated review confirm those of the earlier review, that future research should focus on male CSOs, and CSOs associated with non-help-seeking individuals with gambling problems. The next chapter will discuss the methodological considerations that were used to inform how to undertake such research with these populations.

CHAPTER 5. ONTOLOGICAL, EPISTEMOLOGICAL AND METHODOLOGICAL CONSIDERATIONS

This chapter outlines the ontological and epistemological positions adopted that serve to guide the methodology for the qualitative studies presented in the following two chapters. First, a recap of the contexts for the present investigations will be presented (affected others of non-help-seeking people with gambling problems, and land-based gambling venues operating EGMs), followed by a brief discussion of two key research paradigms, positivism and interpretivism (section 5.1). The aims of this research are then considered, and a rationale is presented for the choice of phenomenology (section 5.2). Husserlerian and Heideggerian phenomenology are then introduced, including a discussion of the Heideggerian concept of time, and the importance of interpreting human experience in the context of the temporal frames; past, present, and future (section 5.2.2–5.2.3).

5.1. Research paradigm

Social science researchers choose from a number of alternative paradigms to approach their work. Each approach has its own set of philosophical assumptions and principles and perspective on how to conduct research (Neuman, 2003). A paradigm's ontological position concerns the nature of reality, while its epistemology is concerned with how we go about capturing this reality (Scotland, 2012). For example, a paradigm influences what phenomena are to be studied, and how to approach and analyse phenomena. Research paradigms, therefore, inform how researchers make decisions about methodological issues. Schwandt (2000) described paradigms as a shared world view representing the beliefs and values in a discipline, which then guide how problems are solved (Schwandt, 2000). Paradigms should be driven by the research question (Cronje, 2014).

The overarching aim of this research was to examine the hidden world of problem gambling where the affected gambler is not actively seeking help, by conducting an inquiry into (1) the

experiences of gamblers and staff interacting with each other in gambling venues, and (2) partners of individuals with a gambling problem who are not seeking help. The contexts of focus in which non-help-seeking was examined were the settings of the family, and land-based gambling venues operating electronic gaming machines. This chapter will explain the rationale for these contexts, and then the ontological and epistemological positions chosen by the primary researcher to guide the methodology. Specifically, how the chosen paradigm was driven by the overarching research question and how this then influenced the decision making around the methodology used.

Families of gamblers with a problem

As discussed in Chapter 1, previous research has identified two potentially useful pathways to promote help-seeking among gamblers with problems. The first is through families (Clark et al, 2007; Pulford et al., 2009). To date, the bulk of the research concerning problem gambling and the role of families, has concerned clinical populations, that is, gamblers with problems who have sought help (e.g., Dowling et al., 2009; Ferland et al., 2008; Wurtzburg & Tan, 2011). For example, studies have examined the role families play during the therapy process for affected gamblers who have sought help (Ingle et al., 2008). Other studies have examined the effect of problem gambling on families. However, among studies of families affected by problem gambling, typically the gambler has acknowledged their problem and families are recruited via problem gambling treatment services (e.g., Mazzoleni et al., 2009; Vachon et al., 2004) or it is not clearly stated whether the gambler has acknowledged their problem (e.g., Dickson-Swift et al., 2005; Holdsworth et al., 2013). Little is known about the experience of families where the gambler is in denial or not seeking help.

To consider how families might potentially offer a pathway to encouraging help-seeking among gamblers with problems, it is necessary to understand the dynamics and issues involved within such families. In other words, an inquiry is needed to examine the private

worlds of families of gamblers with problems where the gambler is not-seeking help or is in denial of having a problem with their gambling.

Gambling venues

Given their regular contact with frequent gamblers, employees in gambling venues may be considered to play an important role in reducing the harm caused by excessive gambling and encouraging help (Allcock, et al., 2002). Furthermore, as noted in Chapter 1, venue staff are among the first point of contact for individuals looking for help with gambling problems, as patrons develop rapport with the staff and view them as trustworthy through their familiarity and regular attendance at the venue (Productivity Commission, 2009). Given the general reluctance of individuals with gambling problems to seek help, as discussed in Chapters 1 and 2 (e.g., Volberg 1997; Delfabbro 2007; Productivity Commission, 2010), and reported low levels of awareness of gambling help services (Hing & Nuske, 2012a), frontline gambling venue staff may provide an important early opportunity to provide information about gambling help, encourage patrons of concern to seek treatment and to facilitate referrals (Hing & Nuske, 2012a). Additionally, there is a growing body of literature concerning the feasibility of venue staff interacting with potential gamblers of concern to reduce harm and refer for treatment (e.g., Allcock, et al., 2002; Hing & Nuske, 2012a; Quilty et al., 2015, as discussed in Chapter 3). The literature review presented in Chapter 4, concerning harm minimisation strategies adopted by gambling venue staff, concluded that venue staff face considerable challenges regarding interacting with identified gamblers of concern.

In view of the significant challenges facing venue staff concerning approaching gamblers identified to be gambling at harmful levels, to consider how staff might effectively facilitate help-seeking, it is necessary to understand the phenomenon of interacting with gamblers in the context of venue staff’s lived world. In other words, gain a deeper understanding of how venue staff experience interacting with gamblers in the context of harm minimisation. In the

same manner, it is also important to examine how gamblers experience harm minimisation strategies in the context of the gambling venue, in particular, how gamblers with potential problems, experience interactions with venue staff around help-seeking. Therefore, to understand the phenomenon of harm minimisation interactions between venue staff and gamblers, an inquiry is needed to examine the phenomena in the context of the lived worlds of both venue staff and gamblers.

5.1.2. The topic of inquiry

There has been growing interest concerning the role of stigma in help-seeking among gamblers with problems (Hing, Nuske, Gainsbury, Russell, et al., 2016). Along with stigma, an unwillingness to admit having a problem is a common barrier to help-seeking among affected gamblers (Suurvali, 2009). Consequently, studies investigating stigma or help-seeking, have often involved participants who have sought help or acknowledged that they have a gambling problem (e.g., Dąbrowska et al., 2017; Itapuisto, 2019; Pulford et al., 2009; Wieczorek & Dąbrowska, 2018). As such, there is a lack of research that has examined the issue of non-help-seeking, in contexts where non-help-seeking is occurring, for instance, families of unadmitted gamblers with problems. Similarly, as reviewed in Chapter 4, while several studies have investigated the feasibility of venue staff implementing harm minimisation strategies, such as approaching potential gamblers of concern with offers of help, there is a lack of literature examining how venue staff experience managing a harm minimisation agenda in the context of their hospitality duties, duties, which are largely aimed at facilitating gambling behaviour. Furthermore, the results of the handful of studies that have been conducted, indicate this presents a significant challenge for venue staff (e.g., Hing & Nuske, 2011a, 2011b, 2012a; Hing et al., 2013).

Given a lack of empirical literature examining these phenomena, the present PhD research was exploratory in nature. The aim was to examine the issue of problem gambling non-help-

seeking, from different perspectives. This research attempts to understand how individuals from different perspectives make sense of help-seeking and non-help-seeking in the context of problem gambling. Help-seeking was examined along with non-help-seeking, to examine the experience of delaying help-seeking and the journey to actively seeking help. Although help-seeking behaviour can be observed and recorded quantitatively, such as the number of individuals with gambling problems who actively seek help versus those who do not, this research aimed to understand the lived experience of help-seeking and non-help-seeking, from the perspectives of gambling venue staff, gamblers, and partners of non-help-seeking gamblers with problems.

Once a decision was made as to the topic of inquiry, the next decision was how to approach this empirical research. Two predominant research paradigms concerning the study of social science have emerged over the past century: positivism and interpretivism (Neuman, 2003).

5.1.3. Positivism and interpretivism

The positivist paradigm is concerned with observation and experimentation and argues that an objective reality exists. From a positivist perspective, to gain knowledge, the inquirer can apply rational thinking and objective observation independently of the cultural and social forces that influence other human activity (Neuman, 2003). Positivism argues that knowledge is gained by observing what we see in external reality, therefore we can learn about people through careful observation of their behaviour (Neuman, 2003). The overarching aim of the positivist paradigm is to search for new laws and theories, as well as test existing ones. Through a positivist paradigm, variables of social phenomena are measured through quantification (Denzin & Lincoln, 2000). For example, a study could investigate the identification of harmful gambling by venue staff, by measuring the number of identified gamblers of concern. Delfabbro, Borgas, et al. (2012) took this approach to investigate how effective staff were in identifying gamblers with problems in the venue.

Further, staff attitudes towards the identification of harmful gambling could be measured by using an ordinal or nominal scale designed to quantify attitudes. Similarly, research investigating the impact of problem gambling on families could quantify the number and severity of gambling-related harms reported by family members, and the number of family members impacted. However, such an approach would not provide us with knowledge about why an individual impacted by problem gambling may have reported a particular gambling-related harm as severe. Similarly, a positivist approach would not be able to explore why a venue staff member did or did not engage with a gambler displaying harmful gambling behaviours.

In contrast to positivism is the interpretivist paradigm. The interpretivist paradigm argues that there are multiple realities, in that; reality involves individual perceptions and interactions with the environment. Therefore, when studying human behaviour, interpretivism is concerned with the meaning of actions, rather than the actions themselves. Importantly, in contrast to positivism, interpretivism believes that in gaining knowledge, the enquirer uses their own preconceptions to guide the process of inquiry and interacts with the individuals under inquiry thereby influencing the perceptions of both parties (Chowdhury, 2014). Rather than quantifying or testing theories of human behaviour, interpretivism is concerned with achieving an empathetic understanding of why behaviour has occurred (Neuman, 2003).

5.2. The current inquiry and the selection of a research paradigm

Through careful consideration of the research aims, it became clear that the philosophical underpinnings and methods of inquiry associated with the positivist paradigm were unable to provide a suitable means of exploring the lived experience of help-seeking and non-help-seeking from the various perspectives of interest (those being family members, venue staff, and gamblers). As a clinician working with people with gambling problems, the primary researcher has been privileged to listen to hundreds of stories told by individuals and their

family members affected by harms associated with problem gambling. These experiences helped to shape the view, that the individual realities of individuals of interest for the current research, were multiple and contextually bound. Approaching this research from the positivist paradigm, holding the principle that truth and reality are purely objective and exist free and independent from the observer, the role of the researcher would be to objectively observe and note reality, without making any interpretation. However, by removing the researcher's engagement in the interpretation and establishment of reality, important meaning and perspectives would remain hidden, as phenomena's mode of appearing can remain hidden (Ricoeur, 1976). The interpretivist paradigm argues that social reality is interpreted by individuals and that knowledge is personally experienced, as opposed to being objectively observed from the outside (Nguyen et al., 2015).

The interpretivist tradition implies a subjective epistemology and the ontological belief that reality is socially constructed (Willis, 2007). Interpretivism argues that to understand what a particular action means, one must interpret in a particular way what the actors are doing (Schwandt, 2000). That is, to understand social action, we need to understand the meaning that the actor gives to their action. In other words, social phenomena need to be understood in the social context in which it was constructed.

The main methods and methodologies used within the interpretivist paradigm include ethnography, case research, action research, and phenomenology (Bhattacherjee, 2012). This research aimed to understand how individuals experience certain phenomena. Specifically, how gaming room staff and gamblers, experience the encouragement of help-seeking within a responsible gambling framework, and how individuals experience living, with a partner who has a gambling problem and who is unadmitted or not seeking help. Considering these aims, the chosen methodology was phenomenology.

5.2.1. Introduction to phenomenology

Sixteenth Century German philosopher Immanuel Kant referred to "things" or "the thing itself" as noumena and the "thing" as it appears to the observer as phenomena. Phenomenology is the science of phenomena (Finlay, 2009). Phenomenology is a term that refers to a range of research approaches that arose from a philosophical movement in the mid seventeenth century. The term derives from the Greek words "phainomenon", which means "to appear" and "logos", meaning "a rational account" (Bunnin, 2004). Phenomenology concerns a logical account of the various manner in which things *appear.* It is concerned with the study of *appearances* as distinct to *reality.* Phenomenology, therefore, is the study of the world as lived by a person, as distinct from studying the world or reality as separate from a person (Valle et al., 1989).

Modern phenomenology is credited as being founded by Husserl in the first half of the twentieth century (Zahavi, 2003). Though the term was used in philosophy writings before the twentieth century, it was Husserl who established phenomenology as a method of studying human consciousness. Contemporary phenomenology is the study of human consciousness from the first-person perspective (Stanford University, 1997). The purpose of a phenomenological research approach is to understand the way phenomena appear to individuals through their experience or in their consciousness. Put in another way, phenomenology is a science of consciousness. It concerns our *conscious experiences* of physical and other objects, rather than the physical objects themselves (Käufer, 2015). In general, there are two broad approaches to phenomenology: transcendental and non-transcendental. Edmund Husserl and Martin Heidegger respectively, are largely credited as the major theorists of these two approaches. The following paragraphs will briefly describe each approach ahead of an explanation as to why a non-transcendental method was chosen for the current research.

5.2.2. Husserl's transcendental phenomenology

Edmund Husserl is widely regarded as the founder of the philosophical movement of phenomenology (Macann, 1993). He had a background in mathematics and aimed to present philosophy as a rigorous science. Husserl believed that philosophy should use a rigorous method to gain access to the way in which phenomena appear to pure consciousness, as well as to how phenomena lead, through consciousness' subjectivity, to the constitution of objective knowledge (Gelan, 2015). To be a rigorous science, Husserl argued that philosophy must remain clearly within the realm of consciousness (Seifert, 2017). He argued that, for phenomenology to be a rigorous science, the phenomenologist must set aside current thoughts, beliefs and judgements, which can bias or cloud an objective view of phenomena. Only by setting aside all preconceived ideas, Husserl argued, can the true meaning of phenomena naturally occur (Moustakas, 1994). In his first book *Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy* (Husserl, 1982), Husserl writes:

> How does, and how can, *consciousness itself* become separated out *as a concrete being in itself?* And how does that which is intended to in it, the perceived thing, become separated out as *"over against"* consciousness and as *"in itself and by itself?"*
>
> (Husserl, 1982, p. 83)

By considering such questions, Husserl developed the method of *epoch* or *bracketing*, a process of suspending all general beliefs and existing judgments about phenomena, to get to its essence. Through the process of bracketing, also referred to as phenomenological reduction, the researcher must consciously set aside all preconceived notions, and objectively describe the phenomena under study. Osborn (1994) describes this process as a

shift from one's natural attitude (conditioned way of experiencing the world) to a more conscious awareness of one's assumptions and the development of a transcendental attitude. Chan et al. (2013) argue that if a researcher chooses to apply a phenomenological reduction, thorough preparation for bracketing is essential before data collection. They argue it should occur as early as considering the research proposal, in addition to during the data collection and analysis process. Several strategies have been described for researchers to bracket their preconceptions, for instance, writing memos throughout the data collection and analysis stages as a way of examining and reflecting on the engagement with the data (Tufford & Newman, 2012).

Through years of working as a clinician speaking with people about gambling problems, the primary researcher was aware that not only listening to people describe their experience, can provide an insight into their world, but paying careful attention to their unique use of language as they describe their experience, can provide an intimate understanding of their private world. People's choice of words as they attempt to describe the meaning of their experience, is in itself, a process of personal interpretation. Hermeneutics is a term used to describe the process of interpretation, typically the interpretation of texts (Sherma & Sharma, 2008). That is, an individual's account of their experience is interpretive, rather than a pure and objective description. For instance, as we listen to an individual's interpretation of their experience, we too are making our own interpretation of their interpretation, as we attempt to understand their intent. This interpretive cycle is referred to as a double hermeneutic. By adopting this particular stance, it became increasingly clear that a Husserlian approach, which would require the suspension of all interpretation, would not have been possible. The primary researcher did not believe it possible for them to bracket and eliminate all their presuppositions. Further, the primary researcher's belief was that their presuppositions could be helpful in the interpretation of participants' experiences.

Further deliberation on the use of either a transcendental (descriptive) or hermeneutic (interpretive) approach to this research, involved careful consideration of the research aims. This research was interested in understanding how individuals make sense of phenomena in certain contexts. For example, how an individual with a gambling problem makes sense of venue staff encouraging help-seeking in the context of a gambling venue, and in turn, how venue staff make sense of encouraging help-seeking in the context of their employment duties. Regarding family members of gamblers with problems, or concerned significant others, the interest was to understand the private worlds of individuals living with a partner with a gambling problem. The emphasis here is on *understanding* as opposed to providing an objective description of the phenomena. In other words, understanding how such individuals make sense of the phenomena of having a partner with a gambling problem who is not actively seeking help or is in denial of having a problem. To ensure that the participants' experience was appropriately interpreted, it became clear that a Husserlian approach of phenomenological reduction was not best suited for the present inquiry.

5.2.3. Heidegger's hermeneutic phenomenology

The principles of German philosopher Martin Heidegger's philosophy have paved the way for the development of interpretive phenomenological research methods to examine and understand the human lived experience, and the science of interpretation of written text (Horrigan-Kelly et al., 2016). Before examining Heidegger's approach to phenomenology, it will be first useful to understand the phenomenological concept of phenomena from a Heideggerian perspective. Heidegger uses three fundamental and related notions of phenomena. In *Being and Time*, Heidegger (1962) explains that the Greek expression for the term phenomenon is derived from the verb *φαίνεσθαι,* which means "to show itself". The first conception of phenomena he introduces is "that which shows itself in itself, the manifest" (Heidegger, 1962, p. 51). Phenomena, Heidegger writes, "are the totality of what lies in the light of day or can be brought into the light – what the Greeks sometimes identified simply

with *τά όντα* (entities)" (Heidegger, 1962, p. 51). However, an entity, Heidegger writes, can "show itself in many different ways, depending on the kind of access we have to it" (Heidegger, 1962, p. 51). Thus, he then introduces a second important notion that an entity can also show itself as something other than what it is.

> Indeed, it is even possible for an entity to show itself as something which in itself it is *not*. When it shows itself in this way, it 'looks like something or other.
>
> (Heidegger, 1962, p. 51)

Heidegger then proceeds to explain that the showing in itself as it is not, he refers to as "seeming" or schein – the Greek "semblance" to appear (resemblance). A simplistic example of what Heidegger means by this, is the seeming of a stone in a pool of water to be larger than it is, or a stick to seem bent as it is inserted into clear water. The third conception of phenomena Heidegger introduces, is the notion of something that shows itself by way of alerting the presence of something else which does not show itself. He uses an example involving the symptoms of a disease, to help explain this notion appearing. In this example, we have the emergence of occurrences in the body presenting themselves as something else. Heidegger explains that these occurrences present themselves as something that they are not: the symptoms indicate something that does not show itself. For example, symptoms of flu – you cannot see "a flu". Certain bodily symptoms indicate the presence of flu: high temperature, clammy hands, runny nose, and sore throat. Heidegger makes the important point: the appearance of something *does not mean that it has shown itself*. Rather, it can mean something has made itself known, which does not show itself to the viewer. As with the disease example, the clammy hands, high temperature and runny nose are like clues to the thing that is not showing itself, that being the flu. The flu, which does not show itself, is the ground for the things that do show themselves, the symptoms. Achieving this uncovering

is the aim of phenomenology. The practice of phenomenology is, therefore, "the art or practice of letting things show themselves" (Smith, 2008).

Heidegger argued that properly understanding the lived experience was, in essence, an interpretative process and that bracketing out preconceptions was neither possible nor desirable (Tufford & Newman, 2012). He questioned whether there is such a neutral transcendental "I" that underlies all acts of consciousness (Frede, 1993) and argued that we and all our activities, are always "in the world" and our being is "being-in-the-world" (Stanford University, 1997), rejecting the idea that consciousness can experience itself in the absence of the world. It is only through immersion in the world, that we have a genuine experience of things (Lewis, 2010). In other words, phenomena are partly a product of their place in the world.

Heidegger went further, arguing that individuals are not necessarily able to fully realise the meaning of experiences, and certain sources of meaning remain hidden. This is because individuals are "in the world", unable to fully separate themselves. Therefore, a certain invisibility or hiddenness is an inherent part of phenomena (Lewis, 2010). By the "invisibleness" of phenomena, Heidegger was referring to the fact that phenomena exist "in the world" and always contain certain mere "givens" or facts. The origin and history of these "givens" are for the most part hidden from us. For Heidegger, the subject is never separated from the empirical world (Lewis, 2010). Rather, the subject is always "in the world". Heidegger described this as "being-in-the-world" and referred to this specific type of "being-ness", that is, being-in-the-world, as *Dasein*.

Dasein

Heidegger argued that ontological inquiry to date did not adequately explain the meaning of Being. In *Being and Time* (1962) he writes:

> Ontological inquiry is indeed more primordial, as over against the ontical inquiry of the positive sciences. But it remains itself naïve and opaque if in its researches into the Being of entities it fails to discuss the meaning of Being in general. And even the ontological task of constructing a non-deductive genealogy of the different possible ways of Being requires that we first come to an understanding of 'what we really mean by this expression "Being"'.
>
> (Heidegger, 1962, p. 31)

Here, Heidegger is arguing that the importance of understanding and defining what is meant by being, cannot be understated. We understand things only so far as they become intelligible to us. An ontology should, therefore, explain how things become intelligible to us. Heidegger writes:

> Basically, all ontology, no matter how rich and firmly compacted a system of categories it has at its disposal, remains blind and perverted from its own most aim, if it has not first adequately clarified the meaning of Being, and conceived this clarification as its fundamental task.
>
> (Heidegger, 1962, p. 31)

Our general existence, or "being-there", is fundamental to us understanding things. Being-there or Dasein, is the entrance point to which things become intelligible to us. Dasein, therefore, provides access to understanding things.

Dasein refers to the experience of being that is uniquely human. The question Heidegger was considering, was not what *is* a being, rather, what does it mean to *be* a being. This type of "being", Heidegger referred to, as "being-in-the-world". What Heidegger meant by us being in the world, was not in the literal physical sense of being *in*, for instance, we are a

biological organism inhabiting a planet, analogous to a chair being *in* a room (Gelven, 1989). According to Heidegger, such subject-object dichotomy results in removing the self out of the world and placing it before the world, as a spectator stands before a picture. However, to *be* a being, is to experience the things from within the world (Zhang, 1993). The *in* of being-in-the world, Heidegger referred to an existential sense of *in*. A useful albeit somewhat simplistic example is the following. A fish living in water cannot see the water and has no sense of being in water, as its complete immersion makes the water disappear. The phenomenology of Dasein, removes the distinction between self and world. Heidegger argues that we experience ourselves as the world in which we are living – we are always already in-the-world, familiar with our world and with being that world.

Dasein's Encounter with the Entities in the world – Everyday Dasein

Heidegger believed that to understand phenomena, we must begin by observing the world as we experience it, including the observation of others (Blattner, 2007). Dasein allows us to understand objects, or entities, and also things we do – human behaviour. We do not understand a person's action as merely inadvertent movement. Rather, we see it as an action and understand it in this manner only because of the way it is nested in the wider context of the person's life story. For example, if an individual is a painter, then they define themselves as a painter, living in the world of a painter, and when they paint, the activity defines them as a painter. When the individual comes across an object such as a paintbrush, they see it as an item that is used to apply paint to their canvas, not as an irrelevant wooden stick with bristles on one end. Heidegger referred to entities that are experienced with such familiarity, as "ready at-hand". That is, we look past the wooden bristled stick, and experience the item as a paintbrush. It is only when the brush fails to work or breaks, that we are taken out of everydayness, and we notice how it is comprised. We see the bristles that are bent or the handle that has come loose. Heidegger referred to entities experienced in this manner, that is, outside of everydayness, as "present at-hand".

When we observe a painter moving paint across a canvas with a brush, we see and understand them to be painting, not just making unintentional movements. We understand the action as being performed by a painter whilst they are being-in-the-world of a painter. We, as observers, are ourselves being-in-the-world and understand that there are painters in the world, and we understand this is what painters do – we have a familiarity with painters and of paintings. Our “access” to the world is comprised by Dasein, our “being-in” the world – our familiarity with the world in which we are embedded (Blattner, 2007). Familiarity is a fundamental characteristic of Dasein (Heidegger & Krell, 2010). Familiarity is not a cognitive phenomenon. Heidegger argued that due to our familiarity with the world, we “know” our way around it, and such “knowing” is not a form of knowing in the sense of a set of beliefs or cognitions. On the Being of entities which we encounter in the environment, he writes: “the kind of dealing which is closest to us is as we have shown, not a bare perceptual cognition, but rather, that kind of concern which manipulates things and puts them into use; and this has its own kind of ‘knowledge’” (Heidegger, 1962, p. 95). The essence of Dasein is familiarity with the world, and such familiarity hides phenomena. Dasein has a tendency to fall into an everyday mode of existence, an immersion into the common world of experience that is readily at-hand (Sherman & Patterson, 2009). Heidegger writes; “that which is ontically so familiar in the way Dasein has been factically interpreted that we never pay any heed to it, hides enigma existential-ontologically” (Heidegger, 1962, p.423). Heidegger uses the example of opening a door to illustrate this concept:

> I open the door, for instance, I use the latch. The achieving of phenomenological access to the entities which we encounter, consists rather in thrusting aside our interpretive tendencies, which keep thrusting themselves upon us and running along with us, and conceal not only the phenomenon of such ‘concern’, but even more those entities themselves *as* encountered of their own accord *in* our concern with them.

(Heidegger, 1962, p. 96)

What Heidegger is saying here, is in stark contrast to the descriptive transcendental method of understanding phenomena. He is arguing that the embeddedness or “in-the-worldness” cannot and should not be separated from entities under study: they are a part of the entity. That is, in understanding human experience we should not begin by conceptualising it in a way that deliberately attempts to filter out everything that is not an object. Rather, we need to understand it in a way that is consistent with the way the world and the phenomena of experience actually occur. Dasein is existentially always “being-in-the-world” and cannot be disentangled or separated from it (Blattner, 2007). Heidegger uses interpretive phenomenology to avoid any attempt of a subject-object method on our description of our everyday experience (Blattner, 2007).

Though largely enmeshed in our everydayness allowing us to navigate our world with familiarity, Dasein does shift outside of everydayness to provide us with glimpses of our uniquely individual possibilities of existence. Heidegger referred to this movement of Dasein between everydayness and self-awareness, as moving between inauthentic and authentic Dasein (Sherman, 2009). For Heidegger, Being-in-the-world (Dasein) must be interpreted according to its temporality: its finiteness. Authentic Dasein has an awareness of its finitude. Heidegger referred to this as “Being-towards-death”. Through awareness of our inevitable mortality, we can fully consider our unique capabilities and potential (Sherman, 2009). Heidegger argued that we do not morbidly await death, rather, we anticipate it (Critchley & Schurman, 2008). In other words, through awareness that we are all moving towards death, that life is finite, we become aware of the urgency to live life with meaning. Awareness of finiteness brings with it an awareness of time.

Heidegger's concept of time

Traditional philosophy has viewed time as a moveable image of eternity. Most notably, Aristotle, who is credited as being the first Greek philosopher to propose a definition of time (Rassi, 2014), approached the concept of time by asking the question: what is time? Aristotle proposed an association between time and motion. He claimed that time is not motion, though it is not independent of motion or transformation (he makes no distinction between motion and transformation (Rassi, 2014). Motion and time, he argues, are not the same thing. In Physics book IV he writes:

> Since time is above all thought to be change, and a kind of alteration, this is what must be examined. Now the alteration and change of anything is only in the thing that is altering, or wherever the thing that is being changed and altering may chance to be; but time is equally everywhere and with everything. Again, alteration may be faster or slower, but not time; what is slow and what is fast is defined by time, fast being that which changes much in a short (time), slow that which changes little in a long (time). But time is not defined by time, whether by its being so much or by its being of such a kind. It is manifest, then, that time is not change.
>
> (Aristotle, 1983, p. 44)

We can indeed describe movement or change as being fast or slow by measuring the time it takes the motion to occur. For instance, something changing in a short period of time we see as fast, and something changing in a long period as slow. It is not time, however, that is moving faster or slower. Rather, it is time by which we ascribe motion as fast or slow, therefore time is not motion: it is defined by motion. Aristotle defines time as the "number of motion in respect of before and after" (Aristotle, 1995, p. 130). He describes time as an

infinite series of “now” points between the past and the future (Aquinas, 2011). Time according to Aristotle is regarded just like any other ontic entity.

Heidegger approached the question of time in a distinctly different manner. He began not by asking “what is time”, but rather from a phenomenological perspective: what does it mean to *be* in time? Heidegger reasoned that our experience of time is more available to us than our speculation. Therefore, it is best understood and described in terms of how humans experience time. We are always *in* the world and *in* time. Time is thus best understood from the perspective of Dasein. Heidegger, therefore, avoids the attempt to objectify time as an ontic entity. He rejected the view of time as being a thing of substance and proposed that time is meaningful only for a being that lives with an awareness of its mortality. That is, time finds its meaning in death (Alweiss, 2002). This was a departure from the tradition of philosophy in which it had long been argued that time finds meaning in eternity. Aristotle saw the essence of time as the “now” which served as a boundary between the future and the past. Time from this perspective is linear: an endless series of “now-points” (Rassi, 2014)(. For Heidegger, the essence of time is the future that is revealed to us in our being-towards-death (Critchley & Schurman, 2008). Humans are beings with limits, and importantly we are aware of our limits, that being our inevitable mortality. Time exists only because we have an understanding of the certainty of death, the certainty of finitude.

Heidegger argued that time could not exist without the Dasein and that it is because of Dasein’s finitude, being-towards-death, that time exists (Alweiss, 2002). In other words, time exists only because we are beings aware of our limits: our mortality; that being our inevitable death. Therefore, to properly interpret being-in-the world, Dasein must be understood according to its temporality: past, present and future (Gelven, 1989). Heidegger writes, “birth and death are connected in a manner characteristic of Dasein” (Heidegger, 1962, p. 427). What Heidegger is inferring here is that Dasein cannot be understood piece by piece. Similarly, a life story cannot be understood in separate parts, rather, its understanding and

interpretation is dependent upon other temporal elements. That is, the human lived experience must be interpreted in the context of the temporal frames; past, present, and future. Removing a story from such context may remove its meaning and therefore our understanding of the phenomenon under study. This is explained nicely by Smythe et al. (2008) in a discussion paper on conducting Heideggerian hermeneutic research:

> Phenomena need to be examined in their existence, in the living world where people find themselves amidst twists and tangles, hopes and dread, doors that open and others that slam shut. To remove a story from its rich textual background is to remove meaning and thus the possibility of understanding the experience as it is lived, for we can only ever live in a context of time, place, and situational influences.
>
> (Smythe et al., 2008, p. 1392)

5.2.4. Ricoeur – language and interpretation

Interpretive hermeneutics facilitates an understanding of phenomena by providing a method of gaining access to Dasein, thereby allowing what is hidden to reveal itself. Heidegger proposed Dasein may express itself through language or discourse:

> Dasein has language. Among the Greeks, their everyday existing was largely diverted into talking with one another, but at the same time they 'had eyes' to see…Man shows himself as the entity which talks.
>
> (Heidegger, 1962, p. 165)

Heidegger argued that language is the fundamental way in which patterns of meaning are manifested to us (Polt, 1999). In applying Heidegger's notion of Dasein to the research

process, the presence of the researcher is recognised, and the researcher is situated fully within the interpretive process. French philosopher Paul Rigour has been credited as building a bridge between phenomenology and hermeneutics by developing a theory of interpretation that takes into account language, reflection, understanding, and the self (Simonÿ et al., 2018). Ricoeur's (1981) theory of interpretation makes the transition from semantics to the application of hermeneutics, with the formulation of the concept of the text, providing a hermeneutic approach to textual analysis.

An essential concept of Ricoeur's (1981) theory of the understanding of text, is "distanciation". According to Ricoeur, the fundamental characteristics of spoken discourse are altered once they become written discourse. Spoken, or "live" discourse has a designated listener, while written discourse, in contrast, is addressed to an unknown audience, and "thereby decontextualises itself from its social and historical conditions of production" (Ricoeur, 1976, p. 14). Essentially, once a spoken discourse becomes textual, it has a different audience: potentially, anyone who can read, therefore the audience is now distanced from the social and psychological context of the original audience (Tan et al., 2009). Ricoeur refers to this distance between the "live" and the written text, as "distanciation" (Ricouer, 1981). What Ricouer is proposing here, is that the written text may not necessarily convey to the reader what the author intended to say. In a practical sense, concerning the analysis of qualitative data, this infers that when analysing transcripts of participants' interviews, it is not possible to entirely recreate the event, for instance, non-verbal cues are absent (Tan et al., 2009). To interpret the participants' lived experience, the researcher is therefore dependent on written text from which they have become distanced (Tan et al., 2009).

Ricouer proposes that written text is the projection of a world of the speaker: "the world of the text" (Ricouer, 1981, p. 140). However, he argues that unlike live discourse, where the speaker and listener share a common context or reality, in written discourse, the speaker

and audience do not share this commonality, due to distanciation, and the text must be interpreted. “To interpret is to explicate the type of ‘being-in-the-world’ unfolded *in front of* the text” (Ricoeur, 1981, p. 141). Ricoeur argues that what must be interpreted in a text is a proposed world, which he refers to as the world of the text, “the world proper to this unique text” (Ricoeur, 1981, p. 142). Interpretation provides the opportunity for the text to reveal its world. Using a hermeneutic approach, Ricoeur describes three fundamental stages of interpretation: initial text reading, critical reading, and appropriation (Terra et al., 2009). Through an initial reading of the whole text, the researcher aims to gain a superficial understanding. This is followed by a more in-depth reading (critical reading) examining possible meanings within parts of the text. The researcher then continues to move between the parts of the text to the whole and repeats this (the hermeneutic cycle) until new insights into what the text reveals is achieved (appropriation). The process of examining an individual’s experience has been described by Smith and Shinebourne (2012) as a double hermeneutic. The research participant is trying to make sense of what is happening to them, and the researcher is trying to understand the participant. Thus, the researcher is endeavouring to make sense of the participant trying to make sense of their experience – the double hermeneutic (Smith & Shinebourne, 2012).

5.3. Conclusion of chapter

In this chapter, it has been argued that the phenomena of non-help-seeking problem gambling is best understood through the voices of individuals living in this world: their lived experience. The use of Heidegger’s view on understanding and interpreting phenomena, provides an opportunity to conduct this research using interpretation as a means of accessing Dasein, therefore allowing the “hiddenness” of phenomena to reveal itself. For instance, to examine a harm minimisation strategy in a gambling venue that involves venue staff facilitating problem gambling help-seeking, more is required than examining only the strategy or policy itself. It can only be properly understood in terms of how a gambling venue

staff member might engage the policy “skilfully”. An approach by a venue staff member to a patron they have identified as gambling in a harmful manner is an action and therefore needs to be understood in the context of the actor’s (the staff member’s) life story. Similarly, a gambler’s response to being approached by a staff member is an action and similarly needs to be understood in the context of their life story.

The primary method employed in the two qualitative studies presented in Chapters 6 and 7 was, therefore, hermeneutical interpretive phenomenology using a Heideggerian philosophical perspective. A qualitative hermeneutical interpretive phenomenological approach facilitated the examination and understanding of the participants’ lived experiences. Through using this approach, emphasis was placed on the notion of “being-in-the-world”, Dasein, and the philosophical stance that human beings are part of the world in which they exist, and are inseparable from that world (Heidegger, 1962). Further, as per a Heideggerian perspective, the notion of time was taken into account when analysing the data. The current qualitative research used in-depth interviews to collect data, the most common method of data collection in phenomenological research (Kvale, 1996). Analysis and interpretation of participants’ lived experience of non-help-seeking problem gambling was investigated from several angles, to achieve a unique in-depth knowledge. The following two chapters will present the two interpretive phenomenological qualitative studies.

CHAPTER 6. AN EXAMINATION OF THE EXPERIENCES AND PERCEPTIONS OF VENUE STAFF AND GAMBLERS CONCERNING THE IDENTIFICATION OF PROBLEM GAMBLING AND REFERRAL FOR TREATMENT

6.1. Introduction

This chapter presents the first of two qualitative studies: an examination of the experiences and perceptions of venue staff and gamblers concerning the identification of problem gambling and referral for treatment. The data presented in this chapter was collected as part of a larger study led by the primary researcher that evaluated referral pathways between gambling help services and gambling venues in South Australia. To address the aims of this thesis, this study's focus is on the perceptions of gamblers and staff around engaging gamblers displaying problem behaviours in the venue. First, a recap of the rationale for this study will be presented followed by the study aims (6.2). The methods used to conduct this study will then be detailed (6.3) including the sampling techniques used to recruit participants across the three focus groups and 11 individual interviews (6.3.1). The data analytic procedure will then be discussed (6.3.2) ahead of the results of the study (6.4). A discussion follows (6.5) which includes acknowledged limitations of the study (6.5.1).

Given the general reluctance of individuals with gambling problems to seek help (Evans & Delfabbro, 2005; Gainsbury, Hing, et al., 2014; Suurvali, Cordingley, et al., 2009; Tavares et al., 2002) and reported low levels of awareness of help services among those with gambling problems (Gainsbury et al., 2014) as discussed in Chapter 2, gambling venues provide a valuable opportunity for staff to inform gamblers of available help services and offer referrals. Consequently, gaming room resources and staff interactions with gamblers may have important public health implications. Particularly, as venue staff are among the first point of contact for individuals looking for help with gambling problems (Productivity Commission, 2010). Frontline gambling venue staff therefore could provide an important gateway to

encourage gamblers with problems to seek treatment and to facilitate referrals (Hing & Nuske, 2012a). As such, there has been increased interest in the degree to which gambling venue staff can identify at-risk gamblers and take an active role in intervening before further harm is endured (Delfabbro, Borgas, et al., 2012; Delfabbro, King, et al., 2012; Delfabbro et al., 2007; Delfabbro et al., 2016).

As discussed in Chapter 3, the evidence to date suggests that while it is theoretically possible to identify individuals with gambling problems in situ using a range of behavioural indicators, there are many challenges facing venue staff if they are to rely on such indicators in practice. A further challenge with regards to venue staff intervening with gamblers identified as potentially having problems concerns the contradiction that exists in that venues, as businesses, are motivated to generate profits whilst concurrently required to discourage problematic gambling, despite the fact that in Australia, gamblers with gambling problems contribute 40% of all money put into electronic gaming machines (Productivity commission, 2010). To date, this "business versus care" paradox has received little empirical attention.

With a greater emphasis being placed on gambling venues to identify and respond to gamblers with potential problems, further research is needed that focuses on how venues can best respond to gamblers to effectively facilitate harm reduction. This study aims to address this gap by presenting a qualitative analysis from a sample of gambling venue staff and gamblers' perspectives on the identification and response to problem gambling in venues.

6.2. Study aims

The study presented in this chapter seeks to examine the help-seeking experience in the context of gambling venues, from the perspectives of, gambling venue staff and gamblers,

and how such experiences affect responding to problem gambling in venues. The aim is not just to describe the experience of identification and response from the perspective of gamblers and staff but understand the phenomena at a deeper level (Merleau-Ponty & Bannan, 1956) taking into account the various challenges, such as stigma and role ambiguity, reported by previous research. This study aims to understand this phenomenon and provide suggestions to improve the effective engagement of gamblers in the venue. Based on these aims and objectives, the following research questions were developed for this study:

- What is the lived experience and meaning to be a gambling venue staff member in a climate of responsible gambling?
- What is the lived experience and meaning to be a gambler in a gambling venue in a climate of responsible gambling?
- How can gambling venues effectively facilitate help-seeking among gamblers who may have gambling problems?

Qualitative research is particularly helpful in providing rich descriptions of complex phenomena (Sofaer, 1999). The primary method used in this study was interpretive phenomenological analysis (IPA) as described by Smith and Osbourne (Smith & Osborne, 2015) utilising a Heideggerian philosophical perspective. IPA is concerned with examining how individuals make sense of their experiences (Pietkiewicz & Smith, 2014). Heideggerian phenomenology views that our experience always occurs and is made sense of within a situated context (Smith & Shinebourne, 2012). Therefore, an experience cannot be simply lifted from an individual's consciousness. Rather, to understand the meaning of an experience to an individual, the researcher must engage and interpret the individual as they themselves interpret and make sense of their own experience. This two-staged analytical process of studying experience is described by Smith and Osborne (2015) as a double

hermeneutic, which can be useful for discovering meaning which may be hidden due to the phenomena's mode of appearing (Smith & Shinebourne, 2012).

6.3. Method

Within the iterative project design, there were two distinct phases of data collection. The first data collection phase involved conducting focus groups with the following stakeholders: individuals with gambling problems in treatment (focus group 1); gaming venue staff (focus group 2); consumer advocates with lived experience of problem gambling (focus group 3).

Focus groups are used to collect specific types of information from clearly identified groups of individuals (Stewart & Shamdasani, 1990). They have an advantage over individual interviews in that the group setting provides a more social environment, as participants influence and are influenced by others – as they are in real life (Krueger, 2015). This is particularly useful when the phenomena of interest involve individuals making decisions that are made in a social context. For instance, a decision by venue staff to approach a patron and initiate a referral to a gambling help service is made involving a discussion with other staff. Therefore, examining this process in a group setting provides a useful medium to obtain rich and valid data. An iterative process was employed whereby data from each focus group were analysed before subsequent groups were conducted. Data from former groups were revisited before moving on to the next, and emerging insights helped inform the semi-structured questions used for the focus groups that followed. While focus groups do have some limitations (Krueger, 2015), it was decided that this was the best way to explore initial themes, which could be followed up by in-depth interviews.

In line with the iterative nature of the study, findings from the focus group analyses then helped to determine the most important questions to follow up in the in-depth interviews conducted in the second phase of data collection with gamblers. This provided an

opportunity to follow up on emerging themes and insights, and to examine these from other target group perspectives, in addition to uncovering new themes as they emerged.

The second data collection phase involved conducting a series of semi-structured individual in-depth interviews with the following two groups: Aboriginal and or Torres Strait Islander individuals impacted by problem gambling; gamblers attending problem gambling counselling. These two groups were purposefully chosen based on themes that had emerged from the stage one focus group analyses. The aim of this second phase of data collection and analysis was to investigate emerging themes in greater depth.

In-depth interviewing involves conducting intensive individual interviews with a small number of participants to explore their perspectives on a particular idea, program, or situation (Cook, 2008). In the current study, interviews were semi-structured to allow the interviewees some control over the direction of the content to be discussed while allowing participants to elaborate or take the interview in new but related directions (Cook, 2008).

6.3.1. Target population and sampling techniques

A mixed purposeful sampling method combining three different strategies (maximum variation; expert; homogenous) that were considered most consistent with the research purpose was used to recruit participants across all focus groups and in-depth interviews. Purposeful sampling is used in qualitative research to select information-rich cases related to the phenomenon of interest (Palinkas et al., 2013). The purpose of this method of sampling is to gain a deeper understanding of the phenomena of interest, rather than to generalise findings to a wider population (Neuman, 2003).

Table 3 presents the target population, sampling techniques and procedure for the three focus groups. A purposeful maximum variation method was used for group 1 (gamblers) to

gain a wide range of age, gender and sociodemographic variation among gamblers. Gamblers were current clients of two local gambling help services. A senior staff member of each service contacted suitable individuals and invited them to participate in the study. For groups 2 and 3 (venue staff; consumer advocates), purposeful expert sampling was used, to target venue staff with experience in approaching gamblers with potential problems, which are predominantly the managers of gaming venues, and a local consumer advocate group was targeted to access individuals with lived experience of problem gambling who had good knowledge of local gaming room policies and procedures.

To recruit venue staff, a representative from the Australian Hotels Association approached suitable individuals and invited them to participate in the study. All interview guides were semi-structured. Groups 1 and 3 focused on gamblers' journey to help-seeking, experience with venue staff interacting with them around problem gambling, experiences with the Gambling Help Line, and experiences with gambling help materials in the venue. Group 2 (venue staff) focused on experience interacting with patrons of concern, experience with available responsible gambling materials in the venue, and experience with interacting with patrons of culturally diverse backgrounds in concerning problem gambling.

Prior to conducting the focus groups, two researchers spent time in the field observing the gambling venue environment, and interactions between staff and patrons. Reflective memos were made which were later used to enhance and inform the interpretive analysis process. A dynamic analysis process was achieved with an observation of environment and participant interactions, reflection by both researchers in situ, and analysis of the actual transcribed data. Table 4 presents the final makeup of the focus groups.

Each focus group was conducted by two researchers: one facilitated the interview; the other operated the recording device and took detailed observational notes which included any remarkable pauses, gestures, and speech dynamics (Biggerstaff & Thompson, 2008).

Immediately following each focus group, the two researchers discussed any notable elements of the group content and their own experiences. These debriefing sessions were digitally recorded and professionally transcribed and incorporated into the analyses.

Based on the initial analysis of focus group data, both purposeful maximum variation and purposeful homogenous sampling were used to recruit participants for the in-depth interviews. From the focus group data, venue staff spoke of challenges they experienced engaging with Aboriginal gamblers. This was an issue we wished to follow up, hence the recruitment aim for individual interviews was to obtain good variation among gamblers in treatment along with targeting several First Nations people with lived experience. Five participants of Indigenous Australian background were purposely selected and a further six participants were recruited from two metropolitan-based problem gambling help services via counsellors. The semi-structured questions for the in-depth interviews explored participants' journey to help-seeking; the influence of important people in the participant's decision to seek help; the influence of participants' cultural background on their decision to seek help; participant's experience with responsible gambling messaging, particularly concerning their journey to help-seeking; experience of venue staff concerning help-seeking.

Table 3. Target population, sampling techniques and procedure for focus groups

Focus Group	Target population	Sampling technique	Location	Group facilitator	Group observer
1	Gamblers in treatment	Purposive maximum variation	University campus conference room	PhD student experienced with focus groups	PhD student experienced with PG treatment
2	Gambling venue staff	Purposive expert	Hotel boardroom central to city	PhD student experienced with focus groups	PhD student experienced with PG treatment
3	Consumer advocates with lived experience of PG	Purposive expert	Meeting room at local GHS	PhD student experienced with focus groups	PhD student experienced with PG treatment

In total, 11 in-depth interviews were scheduled with individuals with lived experience of problem gambling. Nine interviews were conducted as two individuals did not attend their scheduled interview. These individuals were subsequently followed up and, to accommodate their work schedules, offered phone interviews but they declined to participate. The interviews were conducted by the PhD students who collected the data in phase one. The interviews were carried out at locations convenient for the participants and included a university office, the office of a problem gambling help service and the two specialist services. Table 5 presents the characteristics of individuals who participated in the in-depth interviews. All participants in the study provided informed consent and the study received approval from the Southern Adelaide Clinical Human Research Ethics Committee approval reference number 402.13 – HREC/13/SAC/258 (Appendix 5). Participants in the lived experience of problem gambling group received AUS$40 honorarium for their participation.

6.3.2. Data analysis and verification procedures: revealing the phenomenon

With participants' consent, all interviews were digitally recorded. Recordings were then professionally transcribed and checked for accuracy by two researchers. Due to a technical failure, one in-depth interview audio recording was not made and thus a transcript was not produced. This failure was detected immediately after the interview was complete and thus the researcher was able to make detailed field notes about the specific content of the interview, including verbatim quotes. Transcripts were uploaded into NVivo 11 (released 2015) qualitative data software tool. In line with the two phases of data collection, there were two corresponding phases of data analyses. The analytical guidelines for IPA as recommended Pietkiewicz and Smith (2014) were applied. First, audio recordings from the focus groups were listened to and the verbatim transcriptions were read multiple times independently by two researchers. At this stage of the analysis, the focus was directed to what the text was saying (Ricoeur, 1976). Individually, the researchers made initial interpretive exploratory notes during readings which they transformed into potential

emergent themes. The researchers then met to examine connections between potential themes and group them according to conceptual similarities. The same process was then applied to the phase two in-depth interviews data set.

Next, all transcripts were phenomenologically coded and phenomenological clusters developed. Data from the group facilitators' debriefing sessions and observational notes were included at this stage of the analysis, to assist with interpretation of the text. As the text was read and re-read, individual parts of the text were interpreted in the context of the whole dataset. Continual movement between the parts and the whole (the hermeneutic cycle) led to a deeper understanding of the text and allowed us to move from an understanding of what the text was saying, to understanding what it talked about. "The sense of a text is not behind the text, but in front of it. It is not something hidden, but something disclosed" (Ricoeur, 1976, p87). For example, text noting how venue staff were fearful of a negative response from gamblers if they approached them with concern, was initially interpreted as a fear of gamblers who may be angry about losing their money.

Further engagement with the text, supported by observation and reflection on participants' expressions and body language, and the researchers' interpretation of what these processes meant, however, resulted in a deeper understanding of the aforementioned fear. The insight that emerged was that the fear stemmed from staff perceiving they were being hypocritical by encouraging patrons to gamble on the one hand, and then discouraging them if they gambled too much, and gamblers were aware of this perceived hypocrisy and could react adversely. This careful analytical process led to a final list of interpretive superordinate and subthemes. Following the analyses of the focus group and in-depth interview data, findings were combined to enhance data richness. The use of such methodological triangulation provided diverse ways of looking at the same phenomena and enhanced credibility by strengthening confidence in conclusions derived (Carter et al., 2014; Patton, 2015).

6.4. Results

The characteristics of the sample for the focus groups and individual interviews are shown in tables 4 and 5. A total of 34 participants (11 male) comprised three separate focus groups and nine individual in-depth interviews. The majority of participants (68%) were aged between 30 to 49 years and either married, defacto or in a relationship (64%).

Themes emerging from the data

Initial readings of the interviews provided the impression that harm reduction policies in the gaming room created a particularly stressful environment for staff. Furthermore, gamblers (who were largely unaware of such policies) did not believe it was in the venues' interest to implement them rigorously. Early in the analysis, an enormous amount of data was produced concerning individual experiences and perspectives. Through the application of the hermeneutic cycle, (with rich discussion supported by detailed reflective memo-ing by the two researchers, and further debate and discussion by the broader research team to support rigour in data interpretation), the following insights emerged. Although subjective experiences of the phenomena were presented differently in the text, shared meanings were uncovered across the focus groups and individual interviews.

Six themes were revealed through the focus group data which were supported by the in-depth interviews. The in-depth interview data led to the extension of one theme and the emergence of another, resulting in seven themes. Most notably, perceived stigma significantly influenced gamblers' help-seeking behaviour, which tended to be when they had reached crisis point. A personal connection with trusted venue staff was paramount for an effective interaction around problem gambling. The perceived divergence of gaming room staff's hospitality duties and responsible gambling obligations was a discrepancy experienced from many perspectives across focus groups and in-depth interviews and hindered interactions between gamblers and staff.

Table 4. Sample characteristics of 32 focus group participants

Characteristics	Focus group 1: Individuals with problem gambling lived experience, n = 8	Focus group 2: Venue staff, n = 10	Focus group 3: Consumer advocates, n = 7
Gender			
Male	2	1	4
Female	6	9	3
Age			
18-29	0	1	0
30-39	7	5	0
40-49	1	1	4
50-59	0	3	3
60+	0	0	0
Length of time having a gambling problem		NA	
Less than 12 months	1		0
1-2 yrs	1		0
2-5 yrs	1		2
5-7 yrs	1		1
7-10 yrs	1		1
10 + yrs	3		3
Marital status			
Married/defacto	2	2	6
In a relationship	1	3	1
Separated/divorced	2	1	0
Widowed	0	0	0
Single	3	4	0
CALD background?			
Yes	2	0	3
No	6	10	5
Employment status			
Employed full time	6	7	1
Employed part time	1	3	3
Unemployed	0	0	0
Retired	0	0	2
Home duties	0	0	0
Disability pension	0	0	1
Student	0	0	0
Length of time working in a gaming venue	NA		NA
Less than 12 months		0	
1-2 yrs		0	
2-5 yrs		0	
5-7 yrs		1	
7-10 yrs		3	
10 + yrs		6	

Note: NA, not applicable

Table 5. Sample characteristics of 9 in-depth interview participants

Characteristics	Participants
Gender	
Male	4
Female	5
Age	
18-39	0
30-39	1
40-49	3
50-59	3
60+	2
Length of time having a gambling problem	
Less than 12 months	0
1-2 yrs	1
2-5 yrs	3
5-7 yrs	2
7-10 yrs	2
10 yrs +	1
Marital status	
Married/defacto	3
In a relationship	1
Separated or divorced	2
Widowed	0
Single	3
CALD background?	
Yes	6
No	3
Employment status	
Employed full time	1
Employed part time	1
Unemployed	0
Retired	1
Home duties	2
Disability pension	4
Student	0

As the purpose of this research was to examine the help-seeking experience in the context of gambling venues from several perspectives, quantification (e.g., frequency counts) was not undertaken. To illustrate the themes that emerged, relevant examples from the data are presented.

1. Personal Connection

Personal connection related to the importance of rapport between gamblers and gaming venue staff. A genuine and personal connection was crucial between venue staff and

patrons for both the staffs' willingness and confidence in initiating engagement with patrons

around their level of gambling, and for acceptance of such interactions by patrons. Rapport was generally built over time, as indicated by the following participant response:

> "I wouldn't be here today if it wasn't for one of the people in the venues. She didn't approach me outright. She just kept an eye on me, and she'd come around, just quickly, say, "Oh how are you today?" and slowly I got to know her, and with the problems I had I started to confide in her, and on my own bat, I rung up the help, and that's how the staff, I couldn't thank her enough, because it changed my life. But like I said, the venue people, they try, but all depends how you click with them, I think" (Female participant, focus group 1).

The personal connection theme also related to gambling participants' negative experiences with the national gambling telephone helpline and the lack of information about local support services. This was particularly relevant for culturally diverse populations, though several Indigenous Australian participants explained that they would be reluctant to seek help regardless of a good relationship with staff or awareness of services:

> "We're supposed to be strong in culture, strong Aboriginal women, and we do it all on our own. We grew up to be like that." (Female participant, in-depth interview).

2. Role conflict

A perceived conflict between venue staff's hospitality duties and responsible gambling obligations was a discrepancy experienced from many perspectives across all groups. Though not visible initially, multiple readings of the text moving continuously between the parts to the whole, allowed this theme to be revealed across the whole dataset. Venue staff

described experiencing a distinct conflict between expectations to create a comfortable environment for patrons to gamble in, whilst at the same time being mindful of their obligations to monitor patrons' spending and to intervene if necessary. This issue received much attention in the focus groups and was a clear source of stress for venue staff, who at first were reluctant to talk about it. It took around 15 minutes of informal discussion and long periods of silence before staff began to speak openly about this issue. Once they began, however, their tone became more animated and pronounced as they heard other group members share similar experiences. Participants were visibly torn, frustrated, and agitated when describing harm reduction in the context of their duties. Staff were conflicted with the divergence between business and care, as illustrated by the following exchange:

> "There's a very fine line between running a business and caring about your patrons. And I think that's the hardest thing with every person that works in gaming, is that if you remove a big punter and your senior sees that, they go 'what are you doing, you're ruining our income'. Well, hang on, I have a duty of care to my patrons, where's the line?" (Female participant, focus group 2).

Problem gambling participants described being acutely aware of such conflict of roles, which led to any approach by concerned venue staff, being perceived by gamblers as disingenuous or hypocritical. Though many of the gamblers spoke about their desperation for help, they clearly viewed venue staff as promoters of gambling, which significantly hindered any well-meaning harm reduction interactions. The researchers noted the resentment from the gamblers during focus groups 1and 3 (gamblers) when venue-driven harm reduction strategies were discussed and made the comment that gamblers appeared to take particular offense to the perceived hypocrisy.

“They've got a conflict of interest. It doesn't work if its direct staff. You've got management that – they want to keep people there that spend big money. There is a conflict.” (Female participant, focus group 1).

“Yeah. You know that they don't care.” (Male participant, focus group 1).

This perceived hypocrisy also impacted participants’ preference regarding help-seeking, which was best exemplified by the following comments:

Well, it’s not to the pub’s advantage to tell people to leave and not gamble, is it? For me, I wouldn’t use it (gambling help information and support) if it was in the pub. It seems almost hypocritical; you know what I mean?” (Male participant, in-depth interview).

An initial reading of the following comment gave the impression that staff viewed heavy gamblers as ‘out of control addicts’ who could become aggressive if interrupted. However, re-reading the text, moving between the parts to the whole, revealed that staff felt they were constantly shifting between being a hospitality worker, to a counsellor or private investigator, with the latter raising the risk of an adverse response from patrons. Venue staff described feeling they were being forced to make a moral judgement in identifying patrons who were deemed to be overspending. This influenced their reluctance to approach patrons and at times involved a level of fear concerning how patrons might respond.

“But then at what point did our job descriptions include private investigator?” (Female participant, focus group 2).

“So, I feel that even though we do record, and we do speak to them, you’ve got to be careful want you do say and when you do speak to them, because quite often

> they can be quite aggressive. And you're putting yourself into danger in that reason. I've come up to a few aggressive ones." (Female participant, focus group 2).

Venue staff explained they would feel much more comfortable and willing to provide responsible gambling related educational material (information about the nature of gaming machines, details of available help services) to all patrons irrespective of their level of gambling, as it removed the need to make a perceived moral judgment. The following comment illustrates this sentiment which was echoed by gamblers in focus groups 1 and 3.

> "Maybe like if I was trained and I went up to every customer and said, "I'm the duty manager here, I've been trained, this is my new responsibility to advise everybody of the service available if you ever feel like you have a problem". And if you're doing it to everybody, no one is going to feel singled out. So that could kind of get rid of a bit of that issue where if you go up to somebody." (Female participant, focus group 2).

3. The tipping point to help-seeking is individualised

The majority of gambling participants indicated their help-seeking was associated with a point of crisis, such as loss of employment, getting 'caught' or the gambling problem becoming disclosed, or going through a divorce. Help-seeking at this point typically involved phoning the Gambling Helpline or approaching venue staff to initiate a self-barring order. This theme was also based on the shared experience among venue staff of the tendency to initiate contact with a patron of concern only if they displayed overt signs of distress. An initial reading of the following comment gave the impression that staff believed at times feeling as though the entire gaming room was full of gamblers with gambling problems, and that it was not feasible to intervene with them all. However, through a deeper engagement

with the text, it became clear staff found themselves in a difficult position in that they were required to consider which gamblers could afford to lose their money. This was described as a highly individualised and private matter. Staff also felt pressure in making a moral judgement, and their concerns about incorrectly approaching a patron who did not have a problem, that is, making a false positive identification. Consequently, they tended to wait for overt and or disruptive behaviours before initiating an approach.

> "I think the room is full of a lot of problem gamblers, but then I think it's easier to identify when there's a real, real problem. Do you know what I mean? I think we're surrounded by problem gamblers." (Female participant, focus group 2).

> "Because she's a doctor, and she comes in after – she obviously works all night and then she comes in first thing in the morning when she's finished…everyone's done like a gaming report on her, and we do believe what she says is true, that she does have enough money." (Female participant, focus group 2).

Through the in-depth interviews, it emerged that what constituted a motivator for help-seeking was different for each person and that the 'tipping point' existed on a continuum. The majority of in-depth interview participants described accessing help well before experiencing a significant crisis. One male participant reported accessing help when "I was getting close to my moral line". Some participants explained that they were dismissive of gambling help services and responsible gambling material, as they did not view themselves as "problem gamblers". However, some of these same individuals reported accessing help at some point when information was offered, before reaching what might be described as a significant crisis. As such, some individuals though not acknowledging they might have a problem, chose to access help when information was offered at various points before

reaching a state of crisis. Such points included accessing help for co-morbid mental health and substance use issues.

4. Discretion and privacy

Across all focus groups, discretion and privacy were considered paramount in the effective facilitation of help. This related to both the timing and location of interaction between venue staff and patrons, and to the physical placement of responsible gambling messaging and gambling help service information within the gambling establishment. Accessing gambling help information was described as an extremely difficult thing to do. One gambling counsellor reported, “I’ve had clients tell me that it’s too embarrassing to pick up information, that they wouldn’t do it”. Gambling participants indicated the responsible gambling materials in the gaming rooms were largely ineffective, because they were not in a clear frame of mind whilst gambling. Several participants spoke of signage they had seen in the bathroom and explained that this particular material had been effective for two reasons. First, they were able to read the information in a private place. Second, they were away from the gaming room and in a clearer mindset, which allowed them to be more open and receptive of responsible gambling information. The following exchange by group members reveals this point:

> “What has made me think about my gambling when I've been gambling, is if they've had a large advert of seeking help or what are you doing? The men's toilets had a sign on the door as you go in or as you come out. I think there was even one over the urinal from memory, if I could use that expression, and it did make me think what I was doing.” (Male participant, focus group 1).

> “The stuff that's in the gaming room, I bet you it's there, but we don't see it, or we didn't see it, because you deny. You're in denial for a long time.” (Female participant, focus group 3).

> "When you go sit down on the toilet and shut the door, it's the same as females with pap smears (laughs)." (Female participant, focus group 1.)

> "You're away from the machine so you've got time to read something." (Male participant, focus group 1).

Privacy was of particular importance among Aboriginal participants, who described a reluctance to seek help under almost any circumstances. This was due to both significant shame and embarrassment, and a belief that they were responsible for their problem and should therefore be responsible for resolving it alone.

> "We don't like to put ourselves out there. If we've done something wrong, we don't want to have to admit that I suppose. Aboriginal people, we do get really embarrassed about stuff like that, but that's why we don't always say stuff. We just keep it close to us because we're ashamed of it." (Aboriginal Male participant, in-depth interview).

Shame and embarrassment were common experiences among gamblers and resulted in them keeping their problems secret. As the text was read and re-read with continuous movement between individual responses and the dataset as a whole, what emerged was an understanding that privacy had a particular effect on Indigenous Australian respondents. Not talking to anyone about their problem led to a feeling of isolation and a perception that they were the only ones that felt ashamed. This is best exemplified by the following comment.

> "I think Nunga people think that they are the only ones that feel that way but they're not the only ones. Just like when white people first came here, they thought we were animals. We all feel the same way. It's not until 150 years later where we are

> acknowledged as human beings. We are just the same, we just feel like we are the only ones that are ashamed of behaviour". (Aboriginal Female participant, in-depth interview).

5. Organisational inconsistencies

Gambling participants expressed frustration that they could self-bar themselves in one venue then walk across the road to another and continue gambling. This was echoed by venue staff who expressed frustration that due to privacy issues, they could not share information about patrons of concern with neighbouring venues. This led to a feeling of apathy among venue staff in that barring or approaching a patron of concern around their excessive gambling, may not in fact reduce any harm, as the patron may merely attend another nearby hotel.

> "Because like this lady – well most of our customers, if they're barred, what they're going to do is walk down the end of the road, cross over and there's another one" (Male participant, focus group 2).

> "She's just down the road. She's like 200 metres down the road at the next pub. And it's like, well it's just ridiculous." (Female participant, focus group 2).

In these above two comments, it was clear that the participants were frustrated. They had previously discussed how stressful it was to approach a patron of concern about their level of gambling. They explained that even if they did raise the courage to engage the gambler, the gambler would just go and continue gambling at another venue.

Gambling participants suggested that multiple and frequent non-threatening approaches by concerned staff across numerous venues would be more effective in encouraging them to

seek help, even if the approaches were not received well at the time, than a penultimate contact initiated by a ‘red flag’ incident when a patron displays overt signs of distress. The “inconsistencies between organisations” theme was also based on the experiences of problem gambling help service staff who reported that some agencies were much more active in fostering relationships with local gambling venues than others. Also within this theme was the inconsistency between venues in the type and manner problem gambling help service information that was made available to gamblers. The organisational inconsistencies theme was supported also via in-depth interview data, regarding the inconsistent application of barring orders by venues. One participant living in an inner rural city discussed their experience of one venue being highly vigilant in upholding the barring order and refusing entry, and the opposite experience in another venue close by.

6. Lack of awareness

Gambling participants and gaming venue staff expressed a general lack of awareness of the available support services for individuals struggling with gambling issues. Other than the Gambling Helpline, participants were largely unaware of the range of available specific services and the nature of the assistance they provided. This theme was also based on gambling participants’ lack of awareness of the responsible gambling training that venue staff must undertake. In addition, gamblers were unaware of venue staff’s obligations around monitoring patrons’ spending habits, and their duty to identify potential patrons of concern and intervene as necessary. One participant described their lack of awareness that staff were able to offer a suite of options for patrons experiencing difficulties with their level of gambling and believed that venue staff could only assist by facilitating a barring order. This reduced the likelihood of them approaching venue staff for help.

> “I didn’t know how staff would be able to help me, and the only way that I thought that they could help me was to bar me, and I didn’t want to be barred.” (Female participant, focus group 1).

Several other participants agreed with this and noted that this attributed to patron reticence to approach staff unless they wanted to action a self-barring order.

> “Now, nowhere in the gaming venues does it tell you the staff have the information to direct you to the right organisation.” (Female participant, focus group 1).

7. Relapse: a hidden and common experience

This theme emerged through a deeper understanding of the help-seeking process which emerged through the in-depth interviews. With insights gained through these interviews, the focus group text was re-engaged, and the interpretive process continued. It became clear that many gamblers decided to stop gambling well before they accessed formal help. They made many attempts to stop and saw each relapse as a failure, which ironically, made them less likely to seek help. Several participants explained that although they had accessed help at some point, they were very reluctant to access help again following a relapse of their gambling behaviour. One female participant explained:

> “I have had the help before and it’s great, but I think you sort of feel like you don’t want to go back there because you’ve broken your own sort of rules.”

There was significant shame around relapse, with one participant stating they were surprised when they learned that many individuals recovering from gambling problems relapse. The shame and self-stigma around perceived failure, inhibited appropriate help-seeking. This is highlighted by the following participant’s statement:

'Well, you've got to face the person that you've sat with for quite a bit of time and discussed it with and you know in your own head that everything you've said is right, you know, and no, it's not comfortable. It doesn't feel comfortable coming back and saying, 'Hey, I played the pokies again. I failed', you know?" (Male participant, in-depth interview).

6.5. Discussion

This study aimed to examine the experience of identification and response to problem gambling in venues, through qualitative analysis of the perspectives of gambling venue staff and gamblers. The results of this research may provide an insight into how gambling venues could effectively help facilitate help-seeking among gamblers with gambling problems. That being said, notably, the findings also seriously question whether gambling venues and their staff are in fact a suitable means for harm reduction. Given that almost half of gaming machine revenue is generated from gamblers with gambling problems, this is an important question, and it is anticipated that this study will encourage researchers and policymakers to explore this further.

The findings from this study suggest that venue staff approach patrons of concern predominately when they exhibit significant visible overt problem gambling behaviours. This is consistent with findings from previous research (Delfabbro et al., 2007; Thomas et al., 2014). The data suggests three main reasons for this, all which sit within the theme of role conflict.

First, despite venue staff's reported confidence in their ability to identify a patron as potentially having a gambling problem, they are particularly reluctant to overtly make what they perceive to be a moral judgement about a patron. This includes staff's reservations about making incorrect assumptions about a patron's ability to support their gambling,

irrespective of whether they are based on a set of observable indicators. It also includes staff's fears of a negative response such as anger.

Second, the conflict staff experience between their dual roles of facilitating the use of gaming machines in the context of a commercial business, and their obligations to ensure patrons do not gamble excessively, creates a perceived dilemma. This is particularly difficult in situations where staff feel unsupported by upper management. This dilemma results in staff directly engaging with patrons of concern, primarily only when they become visibly distressed or disruptive. Despite continuing improvements in venue staff's confidence in identifying individuals with gambling problems, an aversion by staff to target or single out a patron and share their concern (e.g., by providing information and or referral to treatment) appears to be an important barrier to the dissemination of responsible gambling and treatment service information to those with gambling problems.

Third, venue staff appear to become desensitised to the extent of patron spending and the prevalence of problem gambling behaviours in venues. Again, this results in them identifying and responding to patrons of concern chiefly only when they display significant, clear, and overt problem gambling indicators.

Role conflict experienced by venue staff, was a key theme in the current data, and has been described in previous research as a source of stress among staff (Hing & Nuske, 2012a). The current data suggests that not only is role conflict a source of stress for venue staff, but it also affects their confidence and willingness to directly engage with gamblers about potentially harmful gambling. Staff's trepidation in making judgments about a gambler's level of affordable spending is substantiated by the few studies conducted to date which have demonstrated that venue staff are unable to reliably identify gamblers with problems, despite their training and the use of specially designed behavioural check lists: venue staff have frequently assessed gamblers with problems as not having problems, and gamblers without

problems as having problems (Delfabbro, Borgas, et al., 2012; Delfabbro et al., 2007; Schellink & Schrans, 2004).

The lack of confidence in identifying gamblers with problems described by venue staff in this study is inconsistent with previous research by Hing and Nuske (2011b) who found that the vast majority of participants in their qualitative study involving 48 frontline gambling venue staff, reported they could recognise if a gambler had a problem. Although the venue staff in the current study described a lack of confidence in reliably identifying a gambler as having a problem, they expressed greater assurance in their ability to detect observable behavioural signs of potential problem gambling. That is, confidence in assessing an observed behaviour as potentially problematic was not the same as confidence in assessing a gambler as having a problem. This distinction is consistent with research by O'Mahony and Ohtsuka (2015) who also used a qualitative methodology involving in-depth interviews with gambling venue staff and examined whether staff could identify signs of difficulties that might indicate problem gambling behaviour. The researchers found that, while venue staff were aware of many of the signs of problem gambling behaviours, assessing whether gamblers were gambling in a manner that was causing them harm, was much more difficult to assess. As suggested by venue staff participants in the current study, in some instances, to understand how a person's spending might be causing them harm would require an awareness of their personal circumstances (e.g., level of income, debt, family and dependents) which is clearly outside the venue staff's role description. O'Mahony and Ohtsuka (2015) concluded that "nothing short of telepathy would allow them to understand whether individuals were losing at a level that could have a negative impact for themselves, others or the community" (p. 2317).

Furthermore, the findings in the current study that gamblers also experience the role conflict described by venue staff, and that this perceived hypocrisy inhibits their receptiveness of staff's interactions with them around their level of gambling, is new and has not been

previously reported. Role conflict as described in this study, both for venue staff and gamblers alike, appears to have an important influence on effective engagement between the two parties concerning the provision of responsible gambling information and referral to gambling help services. Specifically, it inhibited effective interactions between venue staff and gamblers intended to encourage help-seeking. Both venue staff and gamblers alike experienced the "business versus care paradox" brought about by venue staff's conflicting roles, and this both mired obligations by venue staff to approach gamblers of concern with offers of assistance, and marred gamblers' reception of such interactions. This represents a clear barrier for the effective promotion of problem gambling harm minimisation and help-seeking behaviour. That venue staff indicated they typically approached only gamblers exhibiting significant overt signs of problem gambling implies at-risk gamblers with less noticeable signs of problems with their gambling receive less attention by staff, thereby reducing opportunities to encourage help-seeking early to both minimise and prevent harm. An additional barrier is that gamblers with problems do not perceive the venue as a place to access help-seeking information.

Overall, gamblers found the gaming room to be an unsuitable location to engage with help messaging due to their state of mind whilst gambling (e.g., 'in the zone'). Discrete areas close to, but not within, the gaming room were seen to be appropriate for the display of responsible gambling messaging and help materials. These findings suggest that it could be helpful if gamblers could access this information privately, and in a context that supports self-reflection and/or personal engagement with the material. For example, bathroom doors, the gaming room foyer, and designated smoking areas of gambling venues.

In addition to role conflict, this study found perceived stigma to be a key driver of gamblers' poor reception of venue staff approaches concerning the promotion of problem gambling harm minimisation and help-seeking. Self-stigma was particularly salient among Aboriginal gamblers and inhibited their motivation to seek assistance, which is in line with previous

research (Hing & Breen, 2014; Hing et al., 2015). Perceived stigma of having a gambling problem and its association with non-help-seeking, has been reported by previous research on barriers to help-seeking among gamblers with a problem, with shame, in particular, a frequently reported barrier (Baxter et al., 2016; Evans & Delfabbro, 2005; Hing, Nuske, Gainsbury, Russell, et al., 2016; Rockloff & Schofield, 2004; Suurvali, Cordingley, et al., 2009; Tavares et al., 2002). Shame was also described in relation to participants' experiences of relapse and their misperceptions about the prevalence of relapse among people with gambling problems, and this inhibited their motivation to seek help. This is in line with previous research reporting that relapse increases self-stigma among gamblers with a problem (Hing et al., 2015).

The point made in the previous paragraph concerning the prevalence of relapse has been highlighted by Prochaska et al. (1992) who modified their transtheoretical model of the stages of change based on research which showed that most people attempting to address substance addictions relapse several times before achieving full recovery. Prochaska and DiClemente's (1983) original model of behaviour change proposed that individuals advance through a series of distinct stages linearly. Their revised model (Prochaska et al., 1992) presents an ascending spiral pattern illustrating that most people relapse while moving through the stages, learn from their mistakes, and try something different the next time. That is, they do not regress to where they began. Moreover, Prochaska et al. (1992) stated "relapse is the rule rather than the exception with addictions" (p.1104) and, upon relapse, individuals feel like failures, become demoralised, and may resist thinking about behaviour change (Prochaska et al.,1992). While the transtheoretical model has undergone some robust criticism e.g., (Herzog, 2005; Sutton, 2001; West, 2005), largely concerning a lack of evidence in support of the model's stage of change algorithm, the view that individuals typically move through change stages in a spiral pattern, with most relapsing, viewing relapse as the norm rather than the exception and an inherent part of the model, is supported by evidence which indicates that 40% to 60% of individuals undergoing

detoxification or rehabilitation for substance use problems, relapse during their recovery (Kabisa et al., 2021). According to Prochaska et al. (2013), when people do relapse, most begin preparing again to address their behaviour. Public health messaging which presents problem gambling relapse as a normal progression towards recovery may serve to reduce public and self-stigma among gamblers and their families and lessen apprehension towards help-seeking.

Gambling venue staff were confused and internally conflicted concerning their responsible gambling obligations, limiting the quality and frequency of interactions with patrons with potential gambling gamblers. At the same time, gamblers demonstrated limited awareness of the responsible gambling training gaming venue staff undertake as part of their role, which in turn contributed to their reluctance in engaging with staff around help-seeking as they did not perceive gaming venue staff to be potential sources of help. To overcome these inhibitors, venues could consider training for gaming venue staff that encourages a greater focus on the provision of responsible gambling information to all gamblers, rather than solely engaging with identified patrons of concern. Providing such information to all gamblers may help to eliminate the current perception that staff are required to make moral judgements about a patron's level of risk to harm, which has been associated with staff reluctance to approach patrons and refer to gambling help services. Whereas the provision of harm reduction material as a matter of course creates an environment conducive to the non-judgemental and open exchange of responsible gambling education and support. The outcome of adopting such an approach across all gambling venues is that all patrons will come to expect a dialogue around responsible gambling practice and available support services at some point. The caveat here, of course, is that the present findings indicate gamblers do not view venues as potential sources of help and perceive venue-based harm reduction initiatives to be insincere.

6.5.1. Limitations

The findings from this study have several limitations that should be considered. The sample is not representative of venue staff or gamblers, and so cannot reveal anything about the prevalence of such experiences. Furthermore, the sample comprised all Australian participants and the views expressed may not represent those from other jurisdictions. All gamblers in this study had accessed treatment at some point and therefore their views may be different from non-treatment seeking gamblers with gambling problems, or gamblers with less severe problems. The views of regular gamblers without problems and gamblers with problems who are not seeking help could be explored in further research.

6.5.2. Conclusion

In summary, harm reduction materials in gambling venues could include personalised local help service information rather than a generic national helpline, particularly for culturally diverse populations. Special attention should be paid to developing effective harm reduction and engagement strategies for Aboriginal gamblers, who are exceedingly reluctant to seek help. That being said, gamblers do not view the gambling venue as a place to access help-seeking information, in part due to the business versus care paradox, and also because they are unaware of staff's harm reduction training and obligations. The results from this study indicate that the involvement of venue staff in the help-seeking process is complex, stressful, conflicted, and often ineffective for both staff and gamblers. The paradox between venue staff promoting gambling whilst discouraging excessive gambling is a conflict experienced by both gamblers and staff and appears to be particularly detrimental to effective engagement between the two. This conflict needs to be taken into account when considering harm reduction strategies in gambling venues. Moreover, the fundamental notion that gambling venues (which are driven by profits), are suitably able to implement and regulate harm reduction policies, requires further exploration.

CHAPTER 7. THE LIVED EXPERIENCES OF INDIVIDUALS IN A RELATIONSHIP WITH A NON-HELP-SEEKING INDIVIDUAL WITH A GAMBLING PROBLEM – A HERMENEUTIC PHENOMENOLOGICAL STUDY

7.1. Introduction

The previous chapter investigated the promotion of help-seeking and staff responses to problem gambling behaviours among non-help seeking gamblers in gambling venues. The present chapter will examine issues around non-help seeking and gambling-related harm by exploring the lived experiences of partners of individuals with gambling problems who are not seeking help. The chapter will begin by presenting the aims for this second qualitative study (7.2.) ahead of the methods used in this study (7.3.) which comprise sampling and recruitment and data collection techniques (7.3.1-7.3.2.), and the data analysis procedures used (7.3.3.). The results will then be presented (7.4.) followed by a discussion (7.5.) which includes the limitations of this study (7.5.1.) ahead of the conclusion (7.5.2.).

Whilst the negative effects of problem gambling are well documented in respect of gamblers themselves (Dowling et al., 2014; McCormack & Griffiths, 2011; Shannon et al., 2017), less research has focused on the experiences of their families and close associates. Studies have estimated four to ten concerned significant others (CSOs) experience the psychological and financial burdens attributed to an individual's gambling problem (Goodwin et al., 2017; Productivity Commission, 2010), most of whom are family members. As discussed in Chapter 3, the limited research in this area has identified three main groups of impacted significant others: partners, children, and parents (Kourgiantakis et al., 2013; Riley et al., 2021). Further, as discussed in Chapter 2, CSOs may provide an opportunity to help motivate non-help-seeking individuals with addictions to seek help, and while there is evidence that CSOs can successfully motivate individuals with substance addictions to seek help using unilateral interventions, the evidence in the context of problem gambling is less

clear. One challenge in adapting family-based interventions in the context of problem gambling treatment refusal, as argued in Chapter 2, is that little is known about families of individuals with gambling problems who are not seeking help. Therefore, the qualitative study presented in this chapter aims to better understand this hidden world through an inquiry into the experiences of partners living with an individual who has a gambling problem and is not seeking help.

7.2. Study aims

To consider how individuals can effectively respond to their treatment-refusing partner with a gambling problem, understanding the private often hidden worlds of individuals living with a partner with a gambling problem in the context of denial or treatment-refusal, is both a logical and epistemologically essential next step. There is a dearth of information concerning the experiences of partners of individuals with a gambling problem in the context of treatment-refusal or denial of the problem. As reported in the systematic review presented in Chapter 4, no study to date has specifically examined the impact of problem gambling among partners of non-help-seeking individuals with gambling problems (Riley et al., 2021). In light of this gap in the literature, the aim of this research presented in the present chapter is to describe the lived experiences of partners living with a person with a gambling problem who either refuses to seek help despite acknowledging that they have a problem or refuses to seek help because they are in denial of their problem.

7.3. Method

The study received ethics approval from the Southern Adelaide Clinical Human Research Ethics Committee (No. 402.13). (Appendix 9).

Theoretical and Analytic approach

An interpretive phenomenological analysis method was used as described by Smith and Osbourne (2015) utilising a Heideggerian philosophical perspective (Heidegger, 1962). As discussed in Chapter 5, Heidegger's philosophy has paved the way for the development of interpretive phenomenological research methods to examine and understand the human lived experience, and the science of interpretation of written text (Horrigan-Kelly et al., 2016). For Heidegger, an individual cannot deliberately detach their consciousness from the world and provide an empirical account of the meaning of phenomena. Rejecting the idea of a transcendental consciousness, Heidegger argued the subject is never separated from the empirical world (Lewis, 2010); rather, he described this as 'being-in-the-world' and referred to this specific type of 'being-ness' as "Dasein'. Interpretive phenomenological analysis is especially valuable when little is known about the phenomenon being studied (De Witt & Ploeg, 2006) and for exploring private worlds and sensitive interpersonal issues (such as the experiences of CSOs of non-help-seeking individuals with gambling problems), respecting and telling that experience from the person's perspective. Therefore, the theoretical framework for this study is hermeneutics underpinned by a subjectivist paradigm.

7.3.1. Sampling and recruitment

To capture the lived experience of living with a partner with a gambling problem who is resistant to seeking help or does not acknowledge the problem, Purposeful sampling was used to select information-rich cases related to the phenomenon of interest (Palinkas et al., 2013). This sampling method was chosen considering the aim was to gain a deeper understanding of the phenomena of interest rather than to generalise findings to a wider population (Palinkas et al., 2013). Participants were recruited through flyers placed in public access buildings such as community centres, shopping centres and public hospitals. The flyers stated that the researchers were seeking individuals living with a partner with a gambling problem who was not actively seeking or receiving help (Appendix 11). Once

potential participants made contact by a telephone call to the researcher, a telephone screening interview was conducted by the primary researcher to determine suitability for the study. If the participant met the eligibility criteria (see below) they were invited to attend for a face-to-face interview.

Individual face-to-face in-depth interviews were used. The interview schedule was informed by a literature review and final questions were discussed and developed by the lead researcher in collaboration with the research team. Interviews were semi-structured and open-ended and covered three broad areas: participants' experience living with an individual with a gambling problem and how it has affected them and their relationship; how the participants have responded when their partner gambled; participants' experience approaching their partner about problem gambling. When investigating the nature of lived experience, qualitative interviews are a useful method of gathering experiential narrative material to enable a rich and deep understanding of the phenomenon (VanManen, 1990).

Participants were South Australian men and women who were living with an intimate partner of the same or opposite sex where the partner had a gambling problem and was not currently seeking help due to treatment refusal or denial of the problem. Inclusion criteria were that the partner of the gambler was 18 years of age or older and that the gambler had a current gambling problem. The individual with the gambling problem was not required to have been formally diagnosed with a gambling disorder. It was sufficient that the affected CSO reported that their partner had a gambling problem. CSOs have been found to be able to report problem gambling behaviour in a reliable and valid manner (Hodgins & Makarchuk, 2003). An initial screening interview was conducted by telephone to assess the following two exclusion criteria. First, risk of abuse or violence to the prospective participant as a result of their participation becoming known to the gambler. Prospective participants were asked a series of questions concerning characteristics of their relationship to the gambler including

any history of domestic violence. Second, participants were excluded if the prospective participant also had a gambling problem, which was assessed via a discussion with the prospective participant about their own involvement with gambling.

Fifteen participants were included in the study (12 females and 3 males) with a mean age of 50 years (SD, 11.84; range 28 – 69). The mean length of relationship with the gambling partner was 9.81 years (SD, 7.61; range 1 – 30). Nine couples had dependent children. Forms of gambling that the gambling partners engaged in comprised land-based EGMs (n = 8), horse racing (n = 4), horse racing and land-based EGMs (n = 1), land-based EGMs, keno and on-line sports betting (n = 1), and online EGMs/slots (n = 1). Of note, three potential participants (all female) did not follow through with arranging an interview after making initial contact, reporting that they were concerned their gambling partner might learn of their involvement which would lead to conflict. All participants interviewed reported that their gambling partner was unaware of their involvement in the study.

Interviews were conducted by the lead researcher. The interviews were carried out at locations convenient for the participants and included a university office and a community-based health centre. Interviews were recorded on a digital audio-recording device and professionally transcribed. All participants provided signed consent and received a $40 valued honorarium gift card for their involvement in the study.

7.3.2. Data analysis and verification procedures: revealing the phenomenon

Transcriptions were uploaded into NVivo qualitative data analysis software; QSR International Pty Ltd. Version 11, 2015. The analytical guidelines for IPA as recommended by Pietkiewicz and Smith (2014) were applied. First, audio recordings were listened to and the verbatim transcriptions were read multiple times by the lead researcher, focusing on what the text was saying (Ricoeur, 1976). Initial interpretive exploratory notes were made

and transformed into 30 potential emergent themes and 23 subthemes. The researchers then met to discuss the interpretive notes and emergent themes. Next, all transcripts were phenomenologically coded and phenomenological clusters developed. As the text was read and re-read, individual parts of the text were interpreted in the context of the whole dataset. Continual movement between the parts and the whole (the hermeneutic cycle) led to a deeper understanding of the text and allowed the researchers to move from an understanding of what the text was saying to an understanding of what it talked about. The meaning of a text is the interaction between the written narrative and the researchers' interpretation. As Ricoeur observes, "the sense of a text is not behind the text, but in front of it. It is not something hidden, but something disclosed" (Ricoeur, 1976, p. 87).
The researchers met several times throughout this analytic process to discuss interpretations and developing themes. The lead researcher and research supervisors undertook regular robust discussions during the analysis period to reach concordance. For instance, early in the analytic process, 'lack of intimacy' emerged as a potential theme. Through further analysis and discussion, it was agreed that 'disconnectedness' more accurately captured the essence of participants' experiences.

The final three transcripts did not yield any novel code dimensions therefore it was deemed we had reached meaning saturation (Hennink et al., 2017). During this phase, it became apparent that the notion of time was an important perspective across the data set and influenced participants' interpretations of their lived experience. The existential of time is a central concept within Heidegger's phenomenology (Heidegger, 1962). Heidegger argued that the human lived experience must be interpreted in the context of the temporal frames; past, present, and future, and that removing a story from such context may remove its meaning and therefore our understanding of the phenomenon under study (Smythe et al., 2008). Subsequently, the lead researcher in collaboration with the research supervisors decided to appraise the phenomenological themes according to the three different timeframes: past, present, and future. This careful analytical process led to a final list of nine

interpretive themes across the three timeframes: two themes each for past and future and five for the present. To illustrate the themes that emerged, relevant examples from the data are presented.

7.4. Results

Table 6 presents the final phenomenological themes within the three timeframes along with supporting exemplificative quotes. The majority of data was grouped under the timeframe of the present, which reflects the emotional state most participants were experiencing in that the problem was current and raw. Many participants were distressed and reported they had not spoken so candidly about their private situation, which largely remained hidden from friends and family. Continued gambling episodes alongside denial of the problem and or the need for help, was among the greatest source of distress for participants.

7.4.1. Past

Social activity

All participants could remember a time when their relationship did not involve problem gambling. That is, none were aware of the gambling problem when they entered the relationship: either the problem was hidden from them, or it developed at a later stage. Some were aware that their partner gambled when they met, while others remembered when their partner began gambling. All participants, however, were unaware of the extent of the gambling or that it was problematic for a considerable time. The theme 'social activity' refers to how gambling was described in the past, before awareness of the problem. For some, it was a fun outing, for example, a day at the races or a night out at a hotel.

Table 6. Dominant themes and exemplificative verbatim quotes arranged according to the three timeframes

Timeframe	Dominant Themes	Exemplificative Verbatim Quotes
Past		
	Social activity	*And then we would make it a day, we'd go to the races; we'd have lunch there or stay behind for dinner. It was an outing, it was good and it was fun.*
	Realisation	*It happened a couple of times and then my frustration hit the limit so I discussed it with him and he confessed.*
Present		
	Role conflict and ambiguity	*I feel like he's my child because I feel like I'm constantly monitoring him like a teenager, what they're up to and are they telling lies, like I'm his mum. And he's 11 years older than me so I'd expect a little bit more – that's the point of going out with someone that's a decade older than you.*
	Stigma	*Because I'm embarrassed about sticking around.*
	Denial	*The anger's about the lying and I think the anger is also his inability to admit that there's a problem, like to me.*
	Health issues	*I mean I get a lot of back pain and I get really really tired at times.*
	Disconnectedness	*We're housemates. Just living together but not – not even communicating about – housemates at least communicate about bills.*
Future		
	Hypervigilance	*How am I going to afford the power bill, the gas bill, and what are we going to do when the rego comes in?*
	Security	*As we get older our needs for finances are going to increase*

Several participants explained that they did not experience it as gambling per se, rather, it was a social outing that involved gambling.

> "It was an outing, it was good and it was fun, and in the beginning, it was a place to go because you really had to dress up at night. We'd go there with probably a member of his family or something sometimes, or just him and I, we'd go for dinner."

Realisation

The realisation of the problem was described by every participant as they recalled the moment they became aware of their partner's problem. This was generally expressed as a time of crisis, and on reflection, a sense of shame in that felt they should have noticed the problem sooner. Anger was also a common experience, as participants described learning the extent of the problem while their partner denied or minimalised it. Verbal conflict was a common experience, with one female participant reporting having been physically assaulted by her gambling partner during a confrontation. The following two comments, each by separate female participants, illustrate the exasperation, disbelief and frustration experienced by CSOs:

> "No idea. I mean I was just devastated, and I just couldn't believe it. And I confronted him and said to him 'where's the money gone, what did you do with it?' He gave me some reasons about 'having the new house and money…' but I knew damn well in the end."

> "You've got to be kidding me. $8,000, [name], where's it gone?" And I said to him, 'You have got to admit that you've got a problem' and he just turned his back and walked away."

Whilst participants made a clear distinction between their relationships before the disclosure of problem gambling, the majority of the conversation concerned the current impact of the problem, which was set in the timeframe of present.

7.4.2. Present

Role conflict and ambiguity

This theme contained a substantial amount of data and refers to the partners taking on additional roles in response to the gambling problem. Their 'dasein' had been modified to accommodate the 'being-in-the-worldness' of a relationship involving problem gambling. To manage the problem, participants had adapted to taking on numerous additional responsibilities which over time affected their relationship. It was a case of the solution becoming a problem. Participants commonly described feeling that they were taking on a parenting role by managing their partners' finances and monitoring their movements. This change in roles had a significant impact on the relationship and though they felt it necessary, most disliked treating their gambling partner like a 'naughty child'.

> "I don't want to be treating him like a child. I don't want to be married to somebody who I have that sort of relationship with."

Female participants commonly described feeling like they were taking on a 'mothering' role, for example hiding money from their partner:

> "It makes me feel like I have to – like I have to mother him and to hide – like I shouldn't have to hide money. But he's basically like a 2-year-old with a credit card."

Taking on an additional mothering role was frequently experienced as a burden due to the extra responsibility:

> "I've had to become more of a mother figure I feel. I've had to take on this additional responsibility; I feel that I've had to do that now. I feel like I'm the responsible one in the relationship."

While participants were clear that they needed to do something to protect themselves from harm, there was ambiguity around where the boundaries of their new role should be drawn, and uncertainty about how long the reorganisation of roles should be in place. It became clear that the change in dynamics in the relationship was a major source of stress for participants. Additionally, there was a sense of loss in that they had lost the support of their partner who in their eyes had become a 'child', at a time when their lives had been thrown into turmoil, and they found themselves managing everything.

> "It's had a huge impact on our relationship down to that it's changed the whole dynamic, the whole power in our relationship has shifted, I think."

The burden of extra responsibility in having to manage the consequences of the gambling problem (such as payment of debts and bills), along with managing harm reduction and minimisation strategies, is illustrated by the following participant's comment:

> "Yep and manage him. So, I'm managing my half. Now I'm managing your half. Now I'm managing you as well."

One participant described how they had returned the role of financial administration to their gambling partner despite knowing they would continue to gamble heavily. This participant explained that she would rather experience the effects of gambling, in return for giving her husband back his "maleness" and surrendering her role of financial administrator.

Stigma

Participants felt they needed to keep the problem secret, as they were concerned if others learned of the problem, they would judge both the gambler and them for continuing to be in the relationship. Frequently, partners were conflicted between wanting to stay in the relationship, but not a relationship that involved problem gambling.

> "I guess it's a reflection on me as thinking these people think I'm an idiot…I'm not going to tell them…but it's more so about how they would treat [name] that I'm trying to protect."

Denial

Frustration regarding the gamblers' lack of acknowledgement of their problem, was a common and particularly upsetting experience among participants. Relationship conflict was reported frequently and typically related to gamblers denying their problem and or gambling behaviour. This affected other parts of the relationship as participants began to question their partners' honesty more broadly. As illustrated by the following participant's comment, partners voiced concern that if the gambler willingly lied about their gambling, they may also be lying about other behaviours harmful to the relationship:

> "It might be a lie as well…so once he's denying about the gambling so other stuff like smoking, drinking, or spending time somewhere, it might be a lie as well."

Overall, there was a strong sense across the data set that trust had been damaged considerably, and was having a damaging effect on the relationships:

> "Well for me that's very difficult because the trust is shattered. I mean you don't know when he's lying and when he's not lying, it's hard to distinguish yeah, what's true, what's not true and it's – well for me it has been very hard."

Exhaustion

Collectively, participants were both physically and emotionally exhausted. Clearly, the impact and lack of acknowledgement by gamblers of their gambling problem was related to numerous physical and emotional ailments. The experience of exhaustion was distinct, and while embedded in the present timeframe, it also related to the past and future. For example, ruminating about their relationship before the problem and how much money had been lost (past), in addition to worries about the future, such as when their partner might gamble again and if there will be enough money for bills (future). This fluidity across the three timeframes is evident in the following participant comment:

> "My health's sliding away (cries). My face is - from all the crying, it's no longer the face it was. I can't get that face back that I had before (cries)."

The first part of this comment is distinctly in the present *"my health's sliding away. My face is…"* The next part of the comment moves to the past perspective as the participant remembers what they used to be, *"no longer the face it was"* before switching to the future as they contemplate not being able to be that person again, *"I can't get that face back"* and then back to the past, "that I had before".

Disconnectedness

The theme of disconnectedness refers to the experience of couples living parallel lives. Related to role conflict, participants described, quite literally at times, feeling as if they were living separate parallel lives under the same roof. This theme also relates to the sense of exhaustion and isolation experienced by participants. A frequently reported consequence of disconnectedness was a lack of emotional and physical intimacy, which largely related to the gambling problem. This sense of disconnectedness was described by both males and females. While discussing how gambling had changed their relationship, one male participant noted that they were now more separate than ever:

> "Well, she watches her [foreign language] TV and I hang with the boy and we watch men's stuff. We're basically in a separate lounge to where she is in the kitchen area so we can basically see each other from where we're sitting but me and him watch footy, cricket, men's stuff and she's got her [foreign language] TV."

Disconnectedness was also illustrated by partners describing the gambler as being constantly distracted or preoccupied with gambling. In the following comment, the participant describes her gambling partner's preoccupation with horse racing:

> "Well just things like having to listen to races. We might be in a conversation and there's a race on and I feel he's not listening to me. There's always races. Even at 10 o'clock at night, we'll be in bed together and he'll put on the headphones for races, and I find races really irritating to listen to."

The disconnectedness theme is further evidenced by the following female participant's comment, where she strikingly describes her experience of living with "another person" rather than her partner.

> "Well, honestly, it's just been like in the last six, eight years or something, it's just been like living with another person not as a partner."

While distress and worry were common experiences contained in the present timeframe, however, there were distinct shared anxieties concerning the future.

7.4.3. Future

The timeframe of future was predominantly concerned with the near future, such as bills that were due and worries about being contacted by debt collectors. Additionally, there was a sense of worry about the longer term, for example, financial security and the relationship in the longer term.

Hypervigilance

While rumination relates to the past, anxiety concerns future worries and feared events that have not happened. Hypervigilance refers to near future worries. This was related to the poor health experienced by participants. They described chronic worry which was present even when there was no detectable gambling. When there were no signs of gambling, participants were worried about when it might happen next. One husband reported worrying every evening if his wife would come home late and then what he would cook for his children. Even on occasions when his wife did come home without gambling, the worry persisted as he worried it might happen the following evening.

> "What am I going to cook for these kids if you [wife] don't come home? Do you think I'm going to sit there and look at them and leave them without food?"

One participant described their experience of implementing harm minimisation strategies while working extended hours to cover gambling debts, and then worrying about how such lifestyle changes might affect their children:

> "It's just – it still is every day waking up and being like what's going happen today? How much is he going to take today? What can I do today to stop that from happening? Should I stay back at work? Should I do the rosters so that I'm working 50 hours just to cover it but then in doing that I'm taking away from my kids?"

The constant presence of worry was a collective experience among participants and related to both the concern about how they were going to meet all their financial obligations, and when the gambler might next gamble:

> "That's the other thing; it's always sitting in the back of my mind. It's a worry, it's a constant worry, it's a constant source of anxiety for me, worrying about how we're going to get everything paid."

The following participant's comment illustrates how constant worry about when their partner might next gamble, created additional vigilance for them as they monitored the gambler's whereabouts:

> "Yes, and I'm anxious all the time he might go in for gambling after work so I was checking when he would be finishing work and that sort of stuff and when will he be home."

Security

This theme refers to longer-term worries such as savings, presents for children at Christmas, will the gambler ever be 'cured', and the future of the relationship. Though hypervigilance is related to this theme, there were two distinct futures in the narratives: near and distant. Several female participants did not want to get married until the gambling problem was addressed, while at the same time worried that they might miss their opportunity to have children if they waited for too long.

> "I think to myself am I wasting my time because I'm at that age where babies are cut-off in a few years, I think to myself gosh. So that's where a lot of the stress and anxiety comes from as well."

Several participants spoke of future consequences they pledged to their gambling partner should they gamble again. They then described worry about further gambling as they did not want to break up the family. Thus, in an attempt to put a stop to gambling by providing an ultimatum, they increased their hypervigilance.

> "If you [the gambling partner] were ever to do this to me and your family again I will leave…I gave it to her and said if you ever do anything like this again, that is the consequence."

Others experienced a reluctance to make plans for the future through fear such plans might be crushed by the gambling problem. Avoidance of making plans with their partner was therefore a protective strategy.

> "I'm reluctant to make any plans for the future with him and the lies are just so destructive, they really are. Like I said, because sometimes I can tell when he's lying but other times I just don't know."

7.5. Discussion

The results from this study provide a rich insight into the lives of individuals living with a partner who has a gambling problem and who is resistant to seeking help or is in denial of their problem (referred to here as unadmitted). To the best of the lead author's knowledge, this is a cohort which has not previously been directly researched. Despite the fact that most individuals with gambling problems do not seek help, partners of non-help seeking individuals with gambling problems have received almost no attention. Moreover, research involving unadmitted gamblers with problems is virtually non-existent since they would be exceptionally difficult to recruit for research purposes. The results of this study, therefore, provide a unique insight into the private worlds of unadmitted individuals with gambling problems. Through the analyses of 15 in-depth interviews based on an interpretive phenomenological method (Pietkiewicz & Smith, 2014), nine dominant themes were revealed. The nine themes showed that participants experiences living with a non-help seeking partner with a gambling problem were characterised by chronic worry, exhaustion, relationship conflict, and an overwhelming sense of isolation.

In terms of discovering the gambling problem, all participants described this as a distinctly distressing moment. The revelation went hand in hand with an initial confrontation which was in most cases, met with denial, and led to conflict. From the moment the problem was exposed, participants experienced chronic hypervigilance as they worried about future gambling episodes.

Participant narratives were interpreted through Heidegger's phenomenological perspective of time. In doing so, the research was able to consider 'what is it like for participants to be *in* time?' According to Heidegger, time is meaningful only for a being that lives with an awareness of its own finality (Alweiss, 2002). This was apparent in the narratives, particularly as participants considered their longer-term future; for example, concern about missing their opportunity to have children. Participants were distinctly aware that the world they were presently in was different than the one they inhabited prior to the revelation of the gambling problem. Their narratives revealed that they were aware of their inevitable mortality, and that they had an awareness of their being-in-the-world and being *in* time. Lived experience, according to Heidegger, must be interpreted in the context of the temporal frames; past, present, and future to understand its meaning and therefore the phenomenon under study.

The health issues among participants described in this study are consistent with previous literature (Wenzel et al., 2008). The lived experience of physical and emotional stress resulting from living with a non-help seeking partner with a gambling problem was one of complete exhaustion. What the narratives revealed was that in terms of coping, partners had taken on additional roles to manage the gambling problem and moderate their emotional distress. Paradoxically, the additional responsibilities only added to their distress at a time when their partners had, in their view, regressed to behaving like a child or teenager, and were thus unavailable for support. This ultimately resulted in an experience of worry, exhaustion, and isolation.

The effect of role conflict on interpersonal relationships was a dominant theme. Such conflict, was in part, related to gendered roles stemming from societal stereotypes. Social role theory pertains that sex differences and similarities in behaviour, reflect gender role beliefs that correspondingly represent people's perceptions of men's and women's social roles in the society in which they live (Eagly & Wood, 2011). This study found, for example,

that, female partners were particularly conflicted about assuming the responsibility of the household finances, and in some instances, even distributing their male partner's "spending" money, thereby, altering the power relationship in the dyad. Previous research has identified, where females acquire increased power in a heterosexual relationship, they face greater difficulty in resolving conflict than male-dominated dyads, particularly among non-Western couples, who face stricter patriarchal norms (Dunbar, 2015). This issue requires further research, especially among ethnic minority groups. Role conflict was also evident among male participants, though for different reasons. For instance, one man described frustration that he had to prepare the family meals due to his wife's absences while she gambled. The data did suggest some differences in how men and women experienced living with a non-help seeking partner with a gambling problem, however, it should be noted that the sample comprised just three male participants. This could be explored with further research, and social role theory (Eagly & Wood, 2011) may provide a useful theoretical framework to do so.

Participant narratives revealed considerable reluctance to turn to friends or family for support due to issues around stigma. The nature of stigma described by participants, related to their concern about both the gambler being negatively evaluated and themselves being judged for providing support to the gambler and remaining in the relationship. First described by Goffman (1963), the 'courtesy stigma' refers to the stigma experienced by individuals who associate with stigmatised groups or persons. Though the role of stigma experienced by people with gambling problems has been examined previously (Hing et al., 2014; Hing, Nuske, Gainsbury, & Russell, 2016), courtesy stigma has only recently been applied to families affected by problem gambling (Matthew et al., 2019). Early indications suggest it could be useful in understanding the impacts of problem gambling on CSOs and help to guide support services. Findings from the present study support this view and highlight this as a potentially useful avenue for future inquiry. There was also some indication that partners were reluctant to actively encourage the gambler to acknowledge their problem and

seek help, due to fears of further harming the relationship. The theory of vicarious help-seeking concerns the intent to help others who appear in need of help, but who are not actively seeking help, and argues that the fear of intervening with a friend (in violence prevention contexts) tends to be proportional to how much they care about damaging the relationship (Williams et al., 2020). This may offer a useful framework from which to investigate vicarious help-seeking, in the context of un-admitted individuals with gambling problems.

The disclosure of intimate partner violence by participants of this study is unfortunately unsurprising given a well-established link between problem gambling and intimate partner violence (Dowling et al., 2014; Roberts et al., 2019), and these findings are in line with previous studies of partners of gamblers with problems, where partners have reported intimate partner violence victimisation (Muelleman et al., 2002; Suomi et al., 2013; Svensson et al., 2013). Intimate partner violence was described by female participants in this study in the context of them voicing concern to their partner over the harmful effects of their gambling. This is consistent with a recent New Zealand qualitative study that examined the impact of problem gambling on affected others and described verbal and physical abuse following arguments about the partner's gambling (Landon et al., 2018).

The finding that partners expressed difficulty in reliably detecting whether the gambler had gambled is in line with previous studies (Heinman, 1987; Makarchuk et al., 2002; Patford, 2009). This was an issue reported across the sample with a variety of forms of gambling including both online and land-based gambling. Behavioural indicators of gambling commonly reported by partners in this study, such as the length time away from home or unaccounted periods of time, may be more difficult to detect among gamblers who wager using a mobile smartphone device. A smartphone allows gamblers the opportunity to gamble anywhere anytime in a wider variety of everyday situations such as watching television or driving (James et al., 2017). Partners of individuals with gambling problems who wager

purely via their mobile device as opposed to more traditional land-based forms may therefore have a distinct experience. This is a potential avenue for future investigation, particularly given the growing involvement with online gambling in Australia (Gainsbury, Russell et al., 2013; Gainsbury, Russell, et al., 2014) and given Australia has among the highest usage of mobile smartphones per capita in the world (Deloitte, 2017).

In the current study, the theme hypervigilance was for the most part related to partners being unable to determine if gambling had occurred. While there were observable signs that participants were able to describe if their partner had gambled, such as a substantial win or loss, importantly, an absence of observable signs did not necessarily mean an absence of gambling. Hence partners experienced ongoing worry about recent losses, increasing debts, and unpaid bills. This was a common experience across the sample. These findings are consistent with the existing literature concerning families of individuals with gambling problems. For example, previous studies have similarly reported that partners of individuals with gambling problems experience chronic hypervigilance (Heinman, 1987; Holdsworth et al., 2013; Krishnan & Orford, 2002).

The lack of confidence in CSOs to reliably detect gambling behaviour is an important consideration for the development of unilateral interventions that rely on the ability of CSOs to respond to gambling behaviour reliably and consistently (such as CRAFT; Hodgins, Toneatto, et al., 2007; Magnusson et al., 2019; Makarchuk et al., 2002; Nayoski & Hodgins, 2016). That said, a recent study involving couples, in which one member had a gambling problem, provides some emerging evidence that partners living with an individual with a gambling problem can influence the gamblers' behaviour (Côté et al., 2019). Further research in this area is necessary.

Several published problem gambling clinical treatment guides advise that stimulus control strategies should be employed, such as asking the gambler to restrict their access to money

by arranging for a family member to manage their financial affairs (e.g., (Battersby et al., 2012; Grant, 2011; Ladouceur & Lachance, 2007; Raylu & Oei, 2010). Such advice highlights the need for individuals to protect themselves and their wellbeing from the harms of living with a family member with a gambling problem. That said, in light of the findings of the current study, it is important to recognise that such strategies may have their own negative consequences which need to be acknowledged and addressed.

7.5.1. Limitations

The strengths of this study include its qualitative exploratory nature. The chosen methodology provided an opportunity to gather rich information allowing the analyses to reveal a deep understanding of a typically private and hidden world that has received very little empirical attention. A further strength is that the sample comprised partners of non-help seeking or unadmitted individuals with gambling problems, which, to the author's knowledge, are a cohort that has not previously been directly investigated. In addition, the gambling partners engaged in a range of gambling activities including horse and sport betting, keno, and land-based and online slots. This provided an insight into the private worlds of individuals impacted by a partner with a gambling problem where a variety of gambling types was involved. That said, the heterogeneity concerning forms of gambling may also serve as a limitation. For example, observable gambling behaviours related to internet gambling on a portable device such as a smartphone, may be less noticeable for partners, than gambling which involves attending a land-based venue for a period away from home. To understand a more complete portrait of the impacts of a specific form of gambling, a relevant homogeneous sample may be more useful.

A further limitation of this study is that the sample was composed entirely of white Anglo-Saxon or European Australians. Therefore, our findings do not inform us of the experiences of individuals from culturally diverse minority groups. Further research that extends this work

across culturally and linguistically diverse groups would be useful. In addition to these limitations, one which raises interesting questions to be taken up in future research is the difficulty we had recruiting male participants. Although we made considerable effort to advertise the study in multiple locations across a metropolitan city, only three males (whom all participated) responded to the study invitation. This may, however, be reflective of prevalence studies that report twice as many males than females experience gambling problems (Williams et al., 2012), suggesting that among heterosexual relationships more female partners may be impacted. Nevertheless, future research could target male partners of individuals with a gambling problem who are unadmitted. Notwithstanding these limitations, this study provides a first step in understanding the experiences of individuals living with a non-help seeking individual with a gambling problem.

7.5.2. Conclusion

In conclusion, this research indicates that partners living with a non-help seeking individual with a gambling problem experience a myriad of emotional and physical health issues. Further, they are reluctant to seek help either formally or via friends and family due to both, stigma concerning the gambling partner, and themselves through stigma by association. Additionally, they find it exceedingly difficult to reliably detect their partners' gambling behaviour and an absence of gambling behaviour, which in turn results in chronic hypervigilance. There is an urgent need for support programs that not only guide partners to help cope with the gambling problem and protect their own wellbeing but also evidence-based strategies and advice that help motivate the treatment refusing or unadmitted person with a gambling problem to acknowledge their problem and seek help. The development of such strategies may provide opportunities for health and community services to promote programs for CSOs that include engagement of non-help seeking gamblers with problems as a clear aim. Though it is not without unique challenges, recent studies indicate early evidence that partners may be able to influence their gambling spouses' problem gambling

behaviour and decision to seek help. Further research is required to progress this line of inquiry, and we hope the current research helps to guide further development in this area.

CHAPTER 8: ROLE CONFLICT AND AMBIGUITY: AN UMBRELLA REVIEW OF LITERATURE REVIEWS

Although several themes were identified on the experience of non-help-seeking in the two qualitative studies presented in Chapters 6 and 7, role conflict and role ambiguity emerged as dominant shared themes across the two studies and will be the focus of the current chapter. The aim here is to review the current knowledge and theories concerning role conflict and role ambiguity, more broadly, and then consider how this literature relates to and may inform the findings of the present research on the phenomenon of non-help-seeking by individuals with a gambling problem. The intention is to interpret the evidence pertinent to role conflict and role ambiguity, in the context of the findings from both qualitative studies. It is anticipated that this will help to provide further insights into role conflict and role ambiguity in the context of problem gambling non-help-seeking and help bring to light potential opportunities to resolve or manage role conflict and encourage help-seeking among affected gamblers.

8.1. Introduction

Role theory concerns one of the most significant aspects of social behaviour, specifically, that people behave in predictable ways dependant on their respective social identities and the situation; that is, their role in relation to others (Biddle, 1986). Role theory has appeared in the social sciences literature for decades across a range of contexts and provides a useful perspective for examining many social issues (Biddle, 1986). Two major concepts derived from role theory are role conflict and role ambiguity. Role conflict occurs when a person must concurrently perform two or more roles that contain incompatible expectations (Biddle, 1986). Role ambiguity occurs when the expectations of a role are incomplete or lack sufficient clarity to guide behaviour (Biddle, 1986).

The contexts in which the theme of role conflict transpired in the qualitative studies undertaken for the current thesis, were broad and included employees in an organisation, gamblers, and individuals in a relationship with an individual with a gambling problem. As role conflict and role ambiguity emerged across a wide range of settings in this research, the areas that will be examined in the following literature review will also be broad and include contexts such as organisational psychology, healthcare, and interpersonal relationships. Given the extensive literature on role conflict and role ambiguity across these areas, published literature reviews, rather than individual studies, were the focus of the review.

Aggregating research findings is an important part of progressing knowledge. The purpose for conducting the following umbrella review was twofold: firstly, to review the body of literature concerning role conflict and role ambiguity; secondly, to allow the primary researcher to then contextualise the findings of the umbrella review with the outcomes of the current research. That is, to examine how the phenomena of role conflict and role ambiguity, create difficulties for those who interact with individuals who have become addicted to gambling. Given the aim of this review was to compile the evidence on role conflict and role ambiguity across a broad range of settings to produce a high-level overview, an umbrella review was used. The purpose of this umbrella review was therefore guided by the following two questions which emerged from this research: 1) What is the knowledge produced about role conflict and role ambiguity across different settings?; and, 2) How do the findings of the current research regarding role conflict and role ambiguity sit within the existing literature?

The first objective, to analyse the knowledge produced about role conflict and role ambiguity, will be the focus of the first part of the current chapter. The second object, to examine the results of the umbrella review in the context of the findings of this research concerning non-help-seeking gamblers with problems, will follow.

8.2. Methods of the review

An umbrella review refers to the compiling of evidence from multiple reviews into one accessible and useable document (Grant & Booth, 2009). Once the research questions for the literature review were developed, the primary researcher met with the research team to discuss and determine the key terms used in the search strategy, and a consensus was reached. The search was designed to cover a broad range of settings such as hospitality, organisational psychology, health, relationships, and families. Given the breadth of fields intended for the search, the Scopus database was used as it covers a wide spectrum of journals and disciplines (Falagas et al., 2008). The structured search strategy was implemented on the 2nd of March 2020 with the assistance of an academic librarian. Literature reviews published in peer-reviewed journals in English from inception through to March 2020 were included. The search terms used are presented in Figure 5.

(TITLE (review)) AND (TITLE-ABS-KEY ((role W/1 (conflict OR ambiguity OR theory)) AND (nurs* OR teacher* OR "care giver*" OR physician* OR parent* OR marriage OR family OR staff OR employee OR relationship* OR partner OR marriage OR marital* OR spouse OR famil* OR addict* OR substance* OR alcohol* OR gambl*)))

Figure 5. Search terms used for umbrella review

Notes. TITLE-ABS-KEY = search on title, abstract and keywords fields

8.2.1. Article selection and inclusion/exclusion criteria

Articles were selected for the umbrella review via a two-stage screening process. First, the titles and abstracts of all articles resulting from the database searches were reviewed, after the removal of duplicates, by the primary researcher. Based on the titles and abstracts, potentially relevant articles were selected for further full text review. This step was

undertaken by both the primary researcher and their primary supervisor. Each full-text item was independently reviewed by both before meeting to confirm the included studies. Where either reviewer was uncertain about study inclusion, the decision to include or exclude was resolved through discussion and cross-checking these studies during that meeting. A table describing the characteristics of studies was developed to extract the data and included the following information: focus or context of the study (e.g., work-life balance); population; type of conflict (role ambiguity, role conflict or both); and, main findings of the review (Appendix 13).

The data extraction table and draft summary of the outcomes were then presented to the other two research supervisors. At this point, it became clear that several articles focused on role conflict and role ambiguity brought about by individuals or stakeholders having different perspectives about a role. That is, the different perspectives or understanding of the role were divergent. This contrasted with role conflict or ambiguity experienced as an internal struggle as individuals negotiated multiple, sometimes incompatible roles. For example, in one article, role conflict was reported in the context of parents of hospitalised terminally ill children and healthcare providers (Bennett & LeBaron, 2019). Though both parents and healthcare providers shared similar roles advocating in the children's best interest, "best interest" was defined differently by these two groups, which led to conflict in how the role of providing for the best interest of the child was carried out. Healthcare providers viewed this as limiting suffering; whereas parents believed they must try every intervention available regardless of the child's discomfort. In this example, the roles were not in conflict per se, as both parties were performing the same role, and they did not express an internal conflict as they performed their role. The conflict was in how the two parties interpreted the role.

The research team discussed this distinction involving role conflict arising from divergent views between groups, and a decision was made to exclude such articles, given that the

internal conflict brought about by performing multiple roles aligned with the current research findings on non-help-seeking problem gambling. That is, the findings of the current research have identified that role conflict in the context of non-help-seeking gamblers with problems, emerged through participants' performing multiple roles and experiencing internal conflict as they negotiated the obligations of each role.

8.2.2. Data synthesis

The findings of all included review articles were synthesised following the Economic and Social Research Council's guidelines on narrative synthesis (Popay et al., 2006). This process involved bringing together the findings of all included review articles, to draw conclusions based on the body of evidence. Articles were uploaded into NVivo 11 qualitative data software tool to help organise the findings. At this stage, an initial reading of the articles was performed to help the primary researcher become familiar with the articles and begin to compare and contrast their findings (Popay et al., 2006). An initial set of clusters concerning the contexts and settings along with the main findings across studies was then developed. The preliminary clusters were presented to the research team for discussion where they were re-grouped based on similarity and meaning. Once consensus was reached the data were synthesised to produce a final set of findings.

8.3. Results

Application of the search terms identified 90 articles. These were then combined into an Endnote library for screening. Following the exclusion of nine articles by reading their title, abstracts and/or full texts were examined for the remaining 81 articles and a further 20 were excluded. The remaining 61 articles were then used to populate the data extraction table. Six articles were then excluded, as the conflict reported referred to different perspectives or

understanding of the roles, rather than an internal struggle. This resulted in a final total of 55 articles selected for the review. The results of this process are presented in Figure 6.

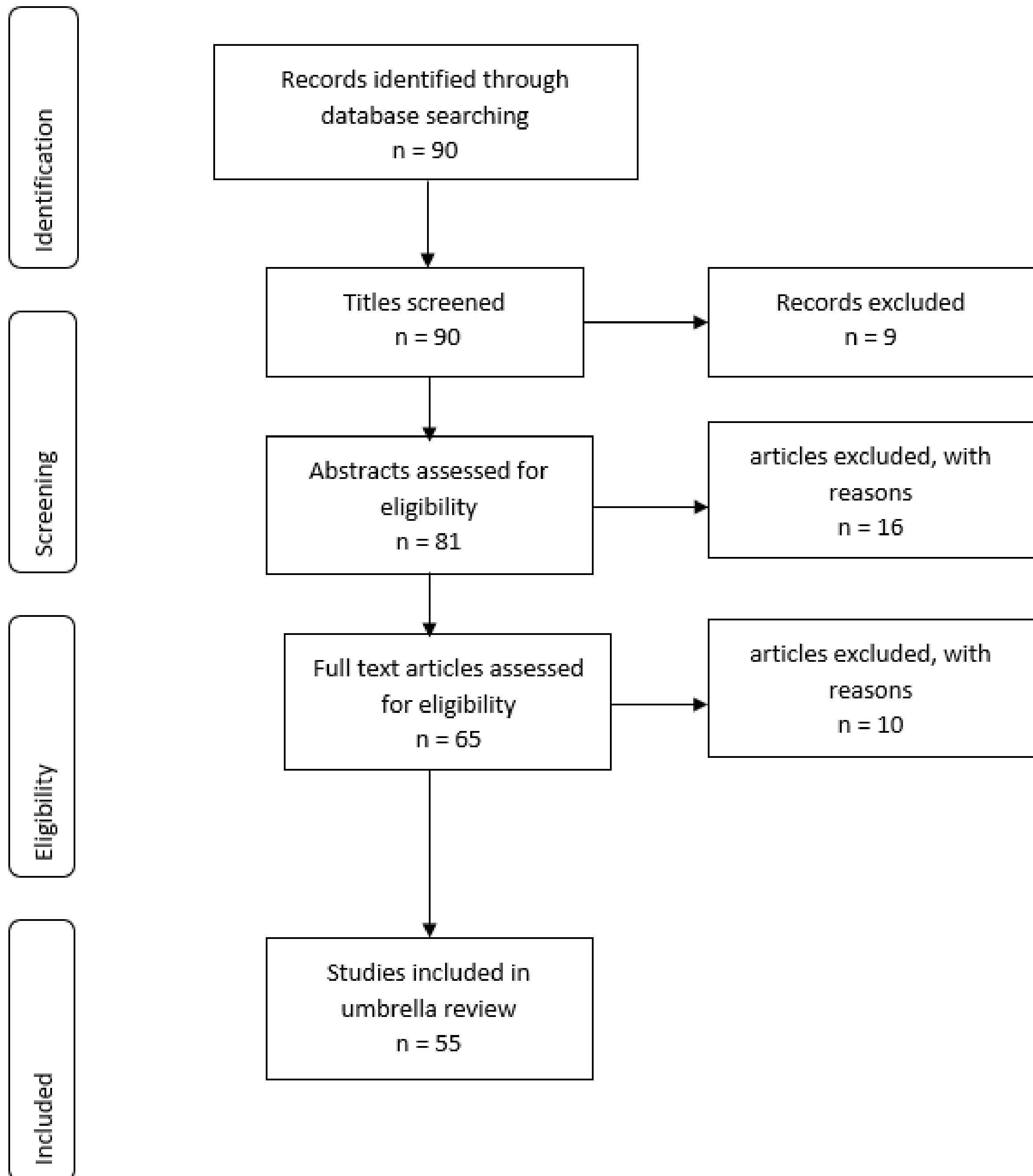

Figure 6. PRISMA flow chart for document selection

The articles covered role conflict in five main areas or social contexts: healthcare, other workplaces, gendered expectations, family caregiving, and intimate relationships. The

healthcare setting contained the most articles (n = 22) followed by other workplaces (n = 13), gender issues (n = 8), family caregivers (n = 7) and intimate relationships (n = 5). Overall, the articles clearly showed that role conflict and ambiguity cause individuals' considerable stress and are detrimental to wellbeing. The findings of this review are organised in the following manner. First, a summary of the ways role conflict and role ambiguity are manifested in each setting is presented. A summary of how both role conflict and role ambiguity contribute to stress follows, ahead of a summary of strategies reported to mitigate role conflict and role ambiguity. This is followed by a synthesis of the main findings concerning role conflict and role ambiguity across all five contexts.

8.3.1. Healthcare

In the healthcare setting, role conflict was described as an overlapping of roles (Almost et al., 2016). The bulk of literature in the healthcare setting concerned nurses. Nurses were particularly affected by role conflict and role ambiguity, which appeared to be related to the complexity of their role. Role ambiguity was a common experience among advanced practice nurses (Faraz, 2016), with some describing their role as somewhere between a nurse and a physician. This led them to feel isolated from other health care providers who displayed clear discipline identities. Further, they felt they could no longer relate to fully advanced practice nurses because they felt they were neither nurse nor physician (Faraz, 2016).

Mental health nurses were another nursing group identified in the review. They perform a broad variety of tasks, which can produce ambiguity in their role. For instance, mental health nurses routinely screen for physical issues among their patients; however, those who

were unclear of their role concerning their patients' physical health, or were untrained in addressing physical health needs, expressed role ambiguity (Blythe & White, 2012).

Increased autonomy (Edwards et al., 2000) and the wide variety of tasks among mental health nurses (Hooper et al., 2016) were reported to contribute to role ambiguity, while decision-making factors influencing the use of patient restraint was a source of role conflict (Riahi et al., 2016).

For nurses whose work involves both clinical practice and teaching/mentoring others, performing concurrent roles was reported as a source of role conflict (Lambert Jr & Lambert, 1988; Lazzari et al., 2015; Lu et al., 2019; Omansky, 2010). Nurses who took on a student supervisor role faced additional role conflict and ambiguity, which stemmed both from balancing the demands of their clinical role with mentoring students, and a lack of formal recognition of their preceptor role by their employer (Omansky, 2010).

Role conflict and ambiguity were described frequently in the hospital setting. Role ambiguity was experienced by doctors and nurses in the intensive care setting concerning end of life decision making. Though it was commonly reported that the physician was the primary decision-maker, the uncertainty of both nurses' involvement in end-of-life decision making and the initiation of end-of-like discussions, created role ambiguity, and was reported as one of the greatest challenges (Flannery et al., 2016). Similar role ambiguity issues were reported among healthcare providers in the medical assisted dying (Fujioka et al., 2018) and palliative care settings (Mulvihill et al., 2010), and mothers of sick children requiring care experienced conflict as they exercised multiple roles such as mothers, wives, and professionals (Carmona et al., 2012).

Two contexts were described in which doctors experienced role conflict: allocating hospital resources; providing sickness certificates. During the allocation of bedside resources, doctors balanced advocating for their patient's health needs with containing the costs of their care. Internal conflict was described as they negotiated to advocate for hospital bedside resources for their patients, whilst observing hospital policy, which was concerned about the

cost and availability of limited resources (Daniel et al., 2008). Role conflict also arose for doctors during the decision-making process in the provision of sickness certificates for their patients (Wynne-Jones et al., 2010). For example, they felt they had a dual role as the patient's doctor and the medical expert for social insurance departments and felt challenged in managing these conflicting roles.

8.3.2. Other workplaces

Role conflict and role ambiguity were common issues in the workplace and were associated with higher staff turnover (Nouri & Parker, 2020), and particularly affected new employees (Saks et al., 2007). The quality of leadership was reported to be an important factor related to both role conflict and role ambiguity (Gerstner & Day, 1997; Podsakoff et al., 2006) as was employees being required to report to more than one supervisor (Maudgalya et al., 2006).

Role conflict was a common experience by employees in the service industry, for instance being required to behave pleasantly to rude customers (Wirtz & Jerger, 2016). Service industry employees also described internal conflict between encouraging customer spending, and their sincerity as to whether this was always in the best interests of their customers (Wirtz & Jerger, 2016).

Employees described role conflict as a common experience in relation to balancing expectations of employment with family and other non-work-related roles (Kossek & Ozeki, 1998; Lambert Jr & Lambert, 1988; Loscocco & Roschelle, 1991; Lu et al., 2019). Balancing the demands of work and study was reported to be the biggest stress factor among PhD students as students balanced the demands of their study, work, and family life (Mackie & Bates, 2019). Financial insecurity was described as a contributing element as students

under financial stress took on additional employment, adding to role conflict (Mackie & Bates, 2019).

Among employees of military organisations, role conflict and role ambiguity were reported as important factors contributing to non-deployment related stressors affecting psychological and work-related outcomes (Brooks & Greenberg, 2018). This came about when employees experienced a lack of understanding of what was expected in their workplace or were unclear about their responsibilities.

8.3.3. Gendered expectations

Although both men and women experienced conflict between work and family roles (Nouri & Parker, 2020), women were particularly affected due to gender-related expectations of the nuclear family. There was one article that reviewed gender role conflict among men, specifically, that gendered role stress was found to be positively correlated to men's reports of anger, anxiety, and engaging in risky health behaviour (Moore & Stuart, 2005). However, most of the gender role literature related to the impact on women. A frequent theme concerned the expectation of women's roles which continued to centre around domestic and family responsibilities, whilst men's centred around work and finances (Agarwal & Lenka, 2015; Worthington & Buston, 1986). Exposure to counter-stereotypical role models was reported to help reduce such influences, for example, girls' exposure to mothers engaged in paid employment, were less likely to experience marriage-career role conflict concerns (Olsson & Martiny, 2018).

In the addiction literature, it has been suggested that internal sex-role conflicts among women create a vulnerability to develop alcohol problems (Forth-Finegan, 2014). However, the use of social role theories to study female alcohol dependence has been criticised for focussing too narrowly on internal sex-role conflict rather than broader political and economic contexts which influence role expectations (Lundy, 1987). Role conflict

experienced between care giving for their family and gambling excessively was reported to be an important factor motivating females with gambling problems to seek help (Holdsworth et al., 2012).

8.3.4. Family caregiving

Role conflict was reported among individuals appointed the responsibility of caring for a family member, which included mothers of sick children, and individuals caring for a partner who had sustained a serious injury. Mothers of sick newborns took on multiple roles such as caregiver, advocate, and expert in their child's condition, along with mother, wife, and housewife (Carmona et al., 2012; Goss, 2017). Role ambiguity was related to maternal depression among mothers of children with epilepsy, which was in turn related to a range of negative child outcomes (Ferro & Speechley, 2009).

Individuals providing care for a partner who had developed a long-term chronic illness and disability experienced role ambiguity during their transition to the caregiver role. They lost their identity as a partner of a healthy individual, and a period of transition ensued as their new identity had not yet formed, which brought about role ambiguity (Gibbons et al., 2014). Additionally, male stroke patients experienced role conflict concerning their masculine identity and role as protectors of the family. At times, they felt infantilised due to their caregiving partner's hyper-vigilance and overprotectiveness (Ramazanu et al., 2019). They were conflicted about the change in role from protector of the family to receiver of care. Due to their concurrent role as health professionals, nurses experienced additional stress stemming from role conflict when a family member was hospitalised. They described an intertwining of dual roles and were conflicted as to when to be a nurse and when to be a family member (Giles & Hall, 2014), and comparable dual role conflict was also present when nurses themselves were hospitalised (Giles & Hall, 2014).

8.3.5. Intimate relationships

Role conflict was reported to emerge among couples during the transition to parenthood as parents took on additional roles. The introduction of children can reorganise roles within the relationship along traditional lines, and lead to role conflict (Twenge et al., 2003). This was also reported among couples who observed roles that ran counter to gendered and cultural stereotypes before the birth of their children (Worthington & Buston, 1986). Problems arose if individuals did not want to observe such traditional social roles (Twenge et al., 2003), and this was more so for women, particularly if they were employed, as they negotiated their caregiving and working roles (Twenge et al., 2003), and less pronounced for males who adopted fewer new roles (Worthington & Buston, 1986). Role conflict increased with the number of children, though was less marked if the children were older, as they demanded less from the caregiving role (Twenge et al., 2003), and lower marriage satisfaction was reported by couples with children compared to those without (Twenge et al., 2003; Worthington & Buston, 1986).

The influence of power in close personal relationships affected role conflict due to strong gendered roles stemming from societal stereotypes (Dunbar, 2015). Heterosexual couples who identified the female as more dominant faced greater difficulty in resolving relationship conflict, and this was more so for non-Western couples due to stricter patriarchal norms (Dunbar, 2015). Furthermore, interpersonal partner violence was reported to be influenced by role conflict. When traditional gender roles are violated by men, they may overcompensate by engaging in dysfunctional traditional masculine behaviours such as violence (Moore & Stuart, 2005).

Role conflict and role ambiguity as a source of stress

Some reports indicated that role conflict does not necessarily mean the roles are incompatible (Loscocco & Roschelle, 1991) and that multiple roles can even have a positive

effect on individuals, such as reducing boredom (Örtqvist & Wincent, 2006) and increasing social identity (Thoits, 1983). However, the majority of articles indicated both role conflict and ambiguity are detrimental to wellbeing.

In the workplace, conflict and uncertainty about roles increased stress and anxiety among employees (Brooks & Greenberg, 2018; Carmona et al., 2012; Edwards et al., 2000; Keim et al., 2014; Lim et al., 2010; Lu et al., 2012; Michel et al., 2011), and was related to lower job satisfaction (Lim et al., 2010; Lu et al., 2012; Lu et al., 2019; Nouri & Parker, 2020; Smith, 2011), job security (Keim et al., 2014), and job performance (Örtqvist & Wincent, 2006; Smith, 2011; Wirtz & Jerger, 2016). Additionally, role conflict and ambiguity predicted employee burnout (Duquette et al., 1994; Edwards et al., 2000; Maudgalya et al., 2006) and turnover (Nouri & Parker, 2020), and employees who experienced conflict and uncertainty with their roles had difficulty adjusting socially within the workplace (Saks et al., 2007) and were more likely to be the target of workplace bullying (Van den Brande et al., 2016). Role conflict was reported to be a greater contributor to employee stress than role ambiguity and role overload (Michel et al., 2011).

In the personal realm, role conflict and role ambiguity were associated with the reorganisation of roles brought about by providing care for a sick family member. Role conflict and ambiguity were related to depression and emotional distress (Carmona et al., 2012; Ferro & Speechley, 2009; Ramazanu et al., 2019), and role conflict was related to male violence towards female partners (Moore & Stuart, 2005).

Strategies to mitigate role conflict and role ambiguity

Among the articles reviewed, several strategies were indicated to mitigate role conflict and role ambiguity in the workplace. Introducing meditation classes in the workplace was reported to reduce role conflict and increase job satisfaction and job performance (Cheng, 2016). Enhancing the clarification of roles was the most frequently reported strategy to

reduce role conflict (Keim et al., 2014; Saks et al., 2007) and role ambiguity (Almost et al., 2016; Brooks & Greenberg, 2018; Edwards et al., 2000; Mulvihill et al., 2010; Omansky, 2010; Podsakoff et al., 2006). A positive relationship between leaders and employees (Gerstner & Day, 1997) and clear communication (Keim et al., 2014) mitigated role conflict. Providing employees with flexible working hours was reported to reduce conflict between work and family roles (Nouri & Parker, 2020), and workplace mentorship programs were reported to help define clear boundaries of roles and reduce role ambiguity (Lim et al., 2010; Nouri & Parker, 2020).

No strategies to mitigate role conflict or ambiguity in the context of personal relationships or family caregivers were found in the articles reviewed. Though role conflict and ambiguity were reported to adversely affect wellbeing within families, none of the articles reviewed addressed how to reduce role conflict issues within the family setting.

8.4. Synthesis of findings

There is some evidence of both positive and negative effects of taking on multiple roles and being exposed to role conflict. The contrasting evidence is consistent with two key hypotheses within role theory: multiple burden hypothesis, and role accumulation hypothesis.

The multiple burden or role strain hypothesis suggests that individuals engaged in multiple roles experience role overload, conflict, and strain (Goode, 1960). Goode's (1960) theory highlights the negative effects of performing multiple roles. When acting out multiple roles, individuals must distribute their resources, such as time and energy, among roles. The more roles one has, the fewer resources they have available to perform each role, creating a vulnerability for role strain which includes role conflict. For example, a parent working night

shift may find their employment role depletes resources needed to coach their child's football team.

However, it was also argued that, although the number of roles an individual performed increased the likelihood of role conflict, it was not purely the number of roles. Rather, it was the isolation or segregation between roles which led to conflict. That is, taking on additional roles did not necessarily lead to role conflict or stress. The effects of taking on multiple roles was not simply additive, but conditional upon the individual's degree of integration of the roles they performed. For example, where roles are well integrated, scarce time and energy can be spent sustaining multiple roles simultaneously (Thoits, 1983).

In contrast to Goode's (1960) role strain theory, Sieber's (1974) role accumulation or expansion hypothesis, suggests that engaging in several roles can benefit an individual's wellbeing. For instance, resources and privileges associated with one role may benefit other roles. For example, wives taking on a paid employment role had a positive effect on marriage stability, as employment improved their family's standard of living and marriage satisfaction (Loscocco & Roschelle, 1991). Further, taking on multiple roles was reported in some cases to have a positive effect among employees, such as reducing boredom (Örtqvist & Wincent, 2006). Similarly, employees who experienced frequent conflict among their roles were more open, flexible, and energised (Örtqvist & Wincent, 2006).

Although the evidence presented across all articles reviewed contained support for both the role strain and accumulation hypotheses, there was greater support for the role strain theory and the detrimental effects of role conflict and ambiguity. Through the examination of role conflict and ambiguity across the 55 articles, four key factors emerged as being particularly important influencers for the negative effects of role strain: two associated with role conflict, and two with role ambiguity. The two dominant influencing factors for role conflict were competing resources among multiple roles, and incompatibility of roles. The two main

influencing factors for role ambiguity were lack of clarity of the role and a wide variety of tasks within the role. These influencing factors will be discussed in the following section.

8.4.1. Dominant influencing factors for role conflict

1. Competing resources

The competing resources among multiple roles factor was largely related to work-life balance. For example, this included college students negotiating employment responsibilities and study commitments (Choo et al., 2019), and higher degree students accommodating work, study, and family duties (Mackie & Bates, 2019). It was also reported among nurses who took on a teaching or academic role as they attempted to balance their clinical work with educational commitments (Lambert Jr & Lambert, 1988; Lazzari et al., 2015). As previously mentioned under gendered expectations, there was one literature review that described a positive impact of competing resources among roles, involving females with gambling problems. Competition between the two roles: gambler and mother, depleted resources required for the role of caregiver, motivating gamblers to seek help (Holdsworth et al., 2012).

2. Incompatibility of roles

Incompatibility of roles was reported more frequently than competition between roles as a source of role conflict. Doctors detailed the incompatibility of roles concerning advocating for their patients while conserving scarce supplies when allocating beside resources. In this context they described such conflict as being both their patients' advocate and their "policeman" or "judge" (Daniel et al., 2008). Incompatibility of roles was also reported as a frequent occurrence by doctors working in general practice regarding issuing sickness certificates. They described discordance between their role as a doctor implementing best practice and meeting the expectations of demanding patients (Wynne-Jones et al., 2010).

Mental health nurses expressed the incompatibility of a caring role with patient safety when physical restraint was required. Nurses did not describe stress resulting from the physical effort or time involved in restraining a patient. Rather, patient restraint created a distinct ethical conflict between providing compassionate and humane care, and the need to ensure the safety of the patient and/or others (Riahi et al., 2016).

Furthermore, the article by Ramazanu et al. (2019) which reviewed studies that examined how couples in the community coped after the stroke of a spouse, described role conflict as a distinct source of stress. Role conflict stemmed from incompatibility of the family protector role with the role of the patient as described by male stroke survivors receiving care from their partners. Partners took on the role of carer and protector of the stroke victim. It was not that the addition of the caregiver role increased the overall number of roles, that was described as a cause of stress. Stress, instead, was brought about by conflict that emerged due to the new role, such as role conflicts between the stroke patient as the care recipient and the spouse as the protector after the stroke (Ramazanu et al., 2019).

Employees in the service industry noted that the role of generating more sales was not always compatible with their commitment to customer satisfaction, for example, encouraging customers to purchase a comparable higher-end product or upselling related complementary items. Performing such concurrent and incompatible roles led to role conflict and associated stress (Wirtz & Jerger, 2016).

8.4.2. Dominant influences for role ambiguity

1. Variety of tasks

Roles that contained a broad variety of tasks were frequently cited as a cause of role conflict, but predominately role ambiguity. Employees in the information technology industry described multiple tasks within their role which led to the unpredictability of work schedules

and role ambiguity. Similarly, mental health nurses described uncertainty and ambiguity brought about by the broad array of tasks within their role (Blythe & White, 2012; Edwards et al., 2000; Hooper et al., 2016).

2. Lack of clarity

As with the variety of tasks within roles, a lack of clarity of the role was also frequently reported as a source of role ambiguity. Individuals who adopted a caregiving role for a family member described role ambiguity stemming from uncertainty of their new role (Gibbons et al., 2014). Caregiver ambiguity arose from the caregivers' new identity being not yet fully incorporated: an unincorporated identity brought about a lack of clarity of the role. A lack of role clarity among nurses in the medical field led to role ambiguity not only for staff (Blythe & White, 2012; Mulvihill et al., 2010), but also for patients. For instance, patients reported being unclear that the nurses' role also included counselling, and so were confused when they were provided with counsel by their nurse, as they did not view it as their role (Tay et al., 2018). Similarly, a misconception that palliative care nurses were involved only in the final stages of a patient's life, created role ambiguity among other health providers (Mulvihill et al., 2010).

8.5. Discussion

The rationale for conducting this umbrella review was to consolidate the evidence exploring role conflict and role ambiguity across a broad range of settings to produce a high-level overview and understanding of these concepts. Overall, 55 review articles were included. By and large, the evidence suggests that both role conflict and role ambiguity across a broad range of settings are detrimental to wellbeing. Individuals experiencing role conflict and or ambiguity reported higher rates of stress, anxiety, depression, burnout, interpersonal violence, and other emotional distress. Furthermore, role conflict and role ambiguity were

related to lower job satisfaction and job performance, and greater employee burnout and turnover.

The healthcare setting contained the greatest number of articles. The majority of these concerned nurses and were related to the complexity of their role in both the community and hospital settings, for instance, addressing both mental and physical needs of patients (Blythe & White, 2012), and balancing clinical practice with teaching or mentoring (Omansky, 2010). Both men and women experienced role conflict, though in different ways around gender-related expectations. Conflict arising from fulfilling paid employment and family roles was reported among women (Agarwal & Lenka, 2015; Olsson & Martiny, 2018; Worthington & Buston, 1986), and men experienced conflict when traditional gender roles were violated (Daniel et al., 2008; Moore & Stuart, 2005), which led to anger, stress, an increase in risky health behaviours, and intimate partner violence (Moore & Stuart, 2005).

When individuals experienced a reorganisation of roles, they were particularly vulnerable to the effects of role conflict and role ambiguity. Two main contexts were reported across the articles reviewed regarding role reorganisation: couples' transition to parenthood; and caring for a family member. Caring for a family member was the most frequently reported situation concerning role reorganisation. Notably, role conflict was experienced by both, carers, and patients alike. Though the impacts of role conflict and ambiguity were widely discussed in terms of how they affected individuals, there was no evidence or discussion presented which explored how these phenomena affected interpersonal relationships between the two parties.

Overall, the results of this umbrella review indicate that the dominant and most frequently reported driving forces for role conflict and role ambiguity across a broad range of settings, from the workplace to interpersonal relationships, are incompatibility of roles and a lack of clarity of roles. Given the pervasive negative effects of role conflict and role ambiguity,

strategies to reduce and manage their occurrence are important. There is an evidence base concerning the management of role conflict and role ambiguity, mostly in the workplace or organisational setting, for instance, clarifying roles (Keim et al., 2014; Saks et al., 2007) and improving communication (Keim et al., 2014), with much less in the healthcare setting. This is surprising given healthcare was the area containing the greatest number of articles.

Notably, this umbrella review found no evidence concerning strategies to mitigate role conflict and or role ambiguity in the areas of interpersonal relationships or family, including family caregivers. This is a gap in the literature given the pervasive nature of the associated negative effects which, as reported, include anxiety, depression, anger, and intimate partner violence. This avenue is an area for future research.

There are some limitations of this review. Firstly, both systematic and narrative literature reviews were included. Although this widened the scope as per the aims of the current umbrella review, it limited the ability to assess the quality of individual studies contained in the review articles. Further, several reviews did not report a systematic search strategy, which prevented the ability to detect potential selection bias. Secondly, the umbrella review approach may favour the selection of more common and readily studied aspects concerning role conflict and role ambiguity, since they are more likely to be included in literature reviews. For example, the possibility cannot be excluded that there are available studies concerning strategies to reduce role strain in interpersonal relationships and that the lack of a sufficient number of articles to date has precluded the necessity to conduct a literature review on that specific topic. That said, the absence of a literature review is indicative that the area lacks attention. Further, by including only literature reviews, it must be acknowledged that more recent potentially relevant individual studies may not have been picked up in this review.

In conclusion, role conflict and role ambiguity have been widely studied in workplace and healthcare settings, though literature is lacking around family and interpersonal relationships,

particularly among minority groups. Dominant drivers for role conflict and role ambiguity across settings are an incompatibility of roles and a lack of clarity of roles. Improving communication and role clarity can reduce conflict and ambiguity in the workplace, and more research is needed to explore mitigation strategies among families and interpersonal relationships.

8.5.1. Integration of role conflict literature with the current research findings

The umbrella review aimed to review the body of literature concerning role conflict and role ambiguity across a broad range of settings. The rationale for conducting the review was to use the findings to contextualise the current knowledge on role conflict and role ambiguity, with the outcomes of the current research (i.e., the qualitative studies presented in Chapters 6 and 7). The purpose of the current chapter, therefore, is to examine how the key shared themes, role conflict and role ambiguity, that emerged from the two qualitative studies, align with the existing evidence concerning role conflict and role ambiguity. The intention is to gain a better understanding of key drivers of non-help-seeking among individuals with gambling problems and highlight areas for future research. Table 7 displays the alignment of the results of the two qualitative studies alongside the evidence concerning role conflict and role ambiguity derived from the umbrella review. This is discussed in the following section which has been arranged in the same manner as the umbrella review results; that is, according to the main drivers of role ambiguity and role conflict: competing resources; incompatibility of roles; variety of tasks; lack of clarity.

Competing resources

There was some evidence in support of the role accumulation hypothesis (Sieber, 1974) across the family and work (Loscocco & Roschelle, 1991), and organisational settings literature (Örtqvist & Wincent, 2006). However, the majority of literature supported Goode's (1960) role strain theory, in that performing multiple roles can lead to competing resources:

the more roles an individual occupies, the greater the likelihood that additional roles will impede the ability to fulfil the obligations of existing roles. A conflict between work and family was the most frequently reported role stressor (for example, Choo et al., 2019; Kossek & Ozeki, 1998; Lu et al., 2019). Administering a scarcity of resources to fulfil the requirements of multiple roles, can subsequently lead to role strain, namely, role conflict and role ambiguity (Goode, 1960).

When applying these theoretical constructs to the current research, several parallels became apparent. Findings from the study presented in Chapter 6 (qualitative study of gambling venues staff and gamblers) showed that staff working in gambling venues described significant pressure stemming from occupying a role associated with the delivery of responsible gambling practices, in addition to their traditional hospitality role. This issue was raised in the literature review presented in Chapter 3, where Delfabbro et al. (2012) argued that effectively monitoring gamblers' behaviour in search of potential problems would likely be impractical for venue staff given their other competing duties. Although the Delfabbro et al. (2012) article raised the issue of venue staff performing multiple roles, the challenges discussed related to competing resources rather than internal conflict brought about by the competing roles. The findings of the current research, presented in Chapter 6, indicated that role strain came about both as a result of performing multiple roles with limited resources, and perceived incompatibility between roles, though conflicting roles was the greatest source of strain. This is consistent with the broader literature on role stress, in that role conflict is considered a greater source of stress than role overload (Michel et al., 2011). Staff were

Table 7. Integration of role conflict umbrella review with research outcomes

Main drivers of role conflict and ambiguity as per synthesised findings from umbrella review	Role conflict and role ambiguity: an umbrella review of literature reviews (evidence derived from the review)	Study 1: Understanding the business versus care paradox in gambling venues: A qualitative study of the perspectives from venue staff and gamblers	Study 2: The lived experiences of individuals in a relationship with a non-help-seeking individual with a gambling problem: evidence from the study
Competing resources	Work life balance: nurses negotiating teaching and employment duties Students balancing work, family, and study responsibilities	Staff described a multitude of tasks associated with their responsible gambling obligations, which were in addition to their traditional hospitality tasks. This was picked up also in the narrative review of responsible gambling policies: hospitality duties competed with RG duties	Partners' accumulation of roles: managing consequences of the gambling problem (debts, bills etc.), managing harm reduction strategies, caring for partner including protection from stigma, caring for children/family, paid and domestic work, and caring for themselves
Incompatibility of roles	Doctors providing care for patients while also acting as 'policeman' or 'judge' e.g., allocation of bedside resources or sickness certificates Mental health nurses providing care while applying physical restraint to patients. Caring for family member: e.g., incompatibility of spouse as family protector whilst receiving care. Service industry: employees' commitment customer satisfaction incompatible with generating more sales.	Incompatibility between venue staffs' business role which promoted gambling behaviour, and their RG role which involved monitoring customers' spending and intervening if necessary Venue staff and gamblers were aware of this perceived incomparability of roles	Reorganised roles which conflicted with traditional patriarchal norms led to role conflict for both gamblers and partners, and impacted on the relationship e.g., disconnectedness

Variety of tasks	Mental health nurses - broad variety of tasks within their role e.g., screening for both mental health and physical health needs	Gambling venue staff described a variety of tasks associated with RG practices, which were unique to gambling venue staff	The role of carer contained a broad variety of tasks such as paying bills, protecting both the gambler and their relationship, supporting their partners emotional needs
Lack of clarity	Caregivers described a lack of clarity as to what their new role entailed Lack of clarity of palliative care nurses' role created ambiguity Lack of clarity of cancer nurses' role created ambiguity for both nurses and patients	Venue staff were unsure at times when to intervene and which gamblers to intervene with given they felt "surrounded by problem gamblers" Lack of clarity led to fears that they might make a false positive identification	Partners were unclear how long they would be performing their carer role, and this lack of clarity led to worry about the future e.g., long-term financial security and their relationship
	Expectation that palliative care nurses involved only at final stages of a patients' life created ambiguity	Due to a lack of clarity around venue staffs' role, gamblers did not view venues as a potential source of help. Nor did they expect venue staffs' role to involve monitoring their wellbeing. Venue staff were aware of this lack of clarity, which hindered their harm minimisation role	Lack of clarity around what the caring role should entail, particularly when problem remained in the unadmitted stage

visibly torn, frustrated, and agitated when describing the conflict, they experienced between creating a comfortable environment in which to facilitate gambling whilst at the same time monitoring for signs of potential problem gambling and opportunities to intervene. In their review of behavioural profiling of individuals with gambling problems in situ, Delfabbro et al. (2012) concluded that multiple indicators should be used by venue staff to detect harmful gambling. Role conflict experienced by staff or gamblers was not considered by the authors. The research presented in this thesis indicates that the role conflict is fundamental and supports the proposition that the roles of venue staff as described, that is, intervening with problematic gambling while promoting gambling, are mutually exclusive, not just difficult.

Findings from qualitative study 2 involving partners of gamblers (Chapter 7), indicated that participants' accumulation of roles due to their partners' gambling problem, led to significant stress. Multiple roles included: managing the consequences of the gambling problem, for example, negotiating with creditors, paying bills and arranging payment schedules; managing harm reduction strategies; caring for children and other family members; fulfilling paid and domestic work obligations; caring for their gambling partner and their relationship; caring for themselves. The latter role, caring for themselves, was frequently neglected, which appeared to be due to resources having been depleted fulfilling multiple and competing roles, leaving participants feeling worried, isolated, and exhausted. This finding is consistent with the outcomes of the systematic review presented in Chapter 4 (gambling-related harm as reported by concerned significant others).

Incompatibility of roles

Numerous examples of conflict brought about by incompatibility of roles were found throughout the umbrella review. A common theme was when a caring role conflicted with an administrative or bureaucratic role, often guided by the organisation or an overarching policy. Of relevance to the current thesis, service industry employees were conflicted between

fulfilling their customer satisfaction role which at times may have involved discouraging a purchase, and their concurrent obligations to their employer concerning generating higher sales and maintaining employer profits (Wirtz & Jerger, 2016). An analogous conflict emerged in qualitative study 1, with gambling venue staff conflicted between generating greater revenue for their employer through facilitating gambling, while caring for their customers, a role which involved monitoring patrons' signs of excessive spending which may indicate potential problem gambling.

In addition to the conflict brought about by the business versus care paradox, some staff expressed concern that driving away heavy gamblers with potential problems along with hotel profits may place their jobs at risk. Thus, the role as an effective salesperson was compatible with their role as provider for their family, as it favoured job security. Contrarily, however, it was incompatible with their role of caring for customers of concern. In other words, staff were forced to choose between two incompatible roles: providing for their family, or caring for customers of concern, which further complicated role conflict and associated stress.

In qualitative study 2, participants described a reorganisation of roles following disclosure of their partner's gambling problem. In many instances, newly adopted roles conflicted with traditional patriarchal norms and led to role conflict for both gamblers and partners. Female participants described an incompatibility between their role as financial administrator and their male partners' role as the protector and provider for their families. The analogy of feeling as if they were mothering their male partners and treating them like a child was used frequently. Female participants described the relationship as having changed from a female–male partnership to a relationship that resembled more a mother–son. Such infantilisation had a particularly negative effect on intimate relationships, to the extent that one female participant reported abandoning her harm minimisation strategies, which meant handing

financial control back to her husband, despite her belief that this would likely encourage him to gamble. Doing so would allow him to regain his role as provider for their family, thus resolving the role incompatibility and conflict. In the previous example, the reorganisation of roles intended to help manage the gambling problem was causing greater harm to the relationship than the effects of problem gambling: the solution became the problem. Challenges that resulted when one adult assumed the parent position while the other adult family member assumed the position of a child, were reported across several articles in the umbrella review and referred to as infantilisation. Infantilisation occurs when an individual is treated in a way that contradicts their level of maturity (e.g., age or experience), such as treating an elderly person in a child-like manner (Gresham, 1976; Marson, 2014). For example, following the stroke of a spouse, partners took on the role of carer. For male stroke victims, the role as a patient was incompatible with their previous perceived role as protector of their family, and they frequently described feeling infantilised by their spouses' hypervigilance and overprotectiveness (Ramazanu et al., 2019).

There is some literature in the area of alcohol addiction which refers to individuals with alcohol problems being infantilised by family (Kaufman, 1985) and clinicians (Carter, 1997), and infantilisation has been reported to reinforce stigma and negative stereotypes of alcohol addiction (Carter, 1997). People with schizophrenia have reported experiencing over-protection-infantilisation by family caregivers, which they felt adversely affected their wellbeing beyond the impacts of the illness itself (González-Torres et al., 2007). In other research, the infantilisation of adults with dementia has been reported to lead to misconceptions about the disease and reinforce negative attitudes toward people with dementia (Jongsma & Schweda, 2018), and exposure to age-inappropriate care has been reported to coerce adults with intellectual disabilities into acts of infantilisation (Capri & Swartz, 2018).

The phenomenon of infantilisation reported across the role conflict literature is consistent with the findings of qualitative study 2, as partners of gamblers with problems frequently expressed their displeasure in treating their partner as a "child" and the adverse impacts this had on their relationship. Infantilisation, however, appears to have been largely overlooked in the area of problem gambling, which is surprising given the widely reported negative impact of stigma surrounding problem gambling (Baxter et al., 2016; Suurvali, 2012), and stigma has been reported to inhibit help-seeking (Travers et al., 2002). Moreover, treatment guides for problem gambling commonly advise that stimulus control strategies be implemented, such as partners or other family members taking over management of the gamblers' finances e.g., (Battersby et al., 2012; Grant, 2011; Ladouceur & Lachance, 2007; Raylu & Oei, 2010).

The primary researcher was able to find just one reference to the term "infantilisation" in the context of problem gambling: a qualitative study by Borch (2012) who examined eight Norwegian households affected by problem gambling. Infantilisation was described by Borch (2012) in one couple's relationship, where a wife reported that the relationship with her gambling husband had become more like mother and son than an intimate couple. Qualitative study 2 in this thesis, has confirmed and extended this finding, indicating that infantilisation is an important consideration with families affected by problem gambling, and though it may be brought about by a well-intended reorganisation of roles within the family in response to gambling-related harm, it may burden an already strained family system with additional stress. Findings from qualitative study 2 also revealed the impact of role incompatibility on couples, in particular, disconnectedness, which was described by both male and female participants.

Variety of tasks

Conflict arising from performing a variety of tasks within a role, as observed in the umbrella review, emerged across both qualitative studies 1 and 2. In study 1, gambling venue staff described a broad range of tasks that fell under their role as a provider of responsible gambling initiatives. Gambling venue staff have several distinct and unique stressors as compared to employees in other areas of hospitality, and though this issue lacks attention, it has been previously raised in the literature (Tiyce et al., 2013) as reported in Chapter 3. The range of responsible gambling tasks was a source of conflict for staff, with one participant questioning why their role included "private detective". This comment was in reference to the obligation that venue staff described in detecting and intervening with gamblers of concern. Despite their training and the presence of relevant codes of practice (as described in Chapter 3), staff found it difficult to determine which gamblers were causing themselves harm, as it was impossible for staff to know each patron's personal circumstances in sufficient detail, if at all.

Participants in qualitative study 2 voiced similar stressors regarding the difficulty in detecting their partner's gambling behaviour. Many were able to describe signs of problem gambling behaviour; however, as they explained, a lack of observable signs did not necessarily mean no gambling had occurred, which led to chronic hypervigilance. This is an issue that makes gambling addiction distinct from substance addiction where the person usually appears visibly intoxicated, and this should be taken into consideration when developing, for instance, support strategies such as unilateral therapeutic interventions for families affected by problem gambling.

A further example of task variety leading to conflict, and one which inhibited help-seeking, was found in qualitative study 2. Caring for a partner with a gambling problem, along with practising harm minimisation strategies, also involved protecting the gambler and the

relationship, from perceived stigma. As described by participants, this led to reluctance to reach out for help, particularly from family and friends. Thus, the task of protecting the gambler and the relationship conflicted with the task of engaging with support, though both tasks were seen as important components of providing care.

Lack of clarity

When roles lacked clarity, role ambiguity resulted, as reported in the findings of the umbrella review. Of relevance to the finding of this thesis, it was reported that while caregivers adapted to their newly acquired role following the onset of illness of a family member, they experienced uncertainty as their identity went through a transition period (Gibbons et al., 2014). Findings from qualitative study 2 indicated that partners had adopted the role of caring for a gambler with an addiction, though they lacked clarity concerning when they could confirm that the gambling problem had been resolved. This led to uncertainty about their future, including their long-term financial security and the future of their relationship.

Also relevant to this thesis, in the healthcare setting, despite nurses reporting that providing counselling to their patients was within their role, patients were unclear about this, and so were confused when their nurse provided them with counsel (Tay et al., 2018). Such role ambiguity is in line with the findings of qualitative study 1. The provision of responsible gambling information and connection with support services is clearly within the gambling venue staff's role (as discussed in Chapter 3). However, gamblers did not view the venue staff, or the gambling venue, as a potential source of help. One participant, a venue staff employee, reported that staff were acutely aware of this lack of clarity or expectation of their role among patrons of the gambling venue and that it hindered their harm minimisation obligations. It was suggested that educating patrons about this aspect of their role may help staff to carry out their responsible gambling duties, which included connecting gamblers to appropriate help services, and therefore potentially encouraging help-seeking.

In qualitative study 2, the ambiguity of the partners' role was particularly pronounced when the gambling problem was first revealed or apparent to them. Amid the crisis, partners expressed a need to take control of financial matters, though this could only really occur once there was an acknowledgement by the gambler that there was a problem. This led to significant conflict among couples. In situations where the problem was acknowledged, there was a lack of clarity as to what role the carer should play, particularly concerning financial management, and typically a period of trial and error ensued until the couples found an arrangement that worked, at least in the short term.

In summary, findings from qualitative study 1 (Chapter 6) revealed that venue staff felt particularly conflicted between generating greater revenue while caring for their patrons. Further, a lack of clarity around the expectations of staff's harm minimisation role was described by both staff and gamblers alike, creating ambiguity which hindered opportunities for meaningful engagement around harm reduction. Findings from qualitative study 2 (Chapter 7) revealed that role conflict within interpersonal relationships was brought about by a re-allocation of roles following the disclosure or detection and subsequent management of a partner's gambling problem. This included the emergence of infantilisation which was related to (1) partners taking over management of the gamblers' finances and (2) chronic hypervigilance which involved the partners' constant monitoring of the gamblers' behaviour and whereabouts, and this behavioural pattern proved particularly harmful for the relationship.

These findings are represented in the following two conceptual models presented in Figures 7 and 8. Figure 7. illustrates the business versus care paradox in gambling venues. The paradox begins with the emergence of a range of problem gambling indicators in the gambling venue (Fig. 7a). Gamblers experience stress as they focus on

chasing losses, stigma, and shame (Fig. 7b) while staff are actively aware of many visible signs of risk as they facilitate gambling (Fig. 7c). The delivery of gambling products and response to problem gambling by venue staff are guided by responsible gambling policies and venues' codes of conduct. While gamblers may be aware of various posters and pamphlets concerning responsible gambling in the venue, they do not view venues, including

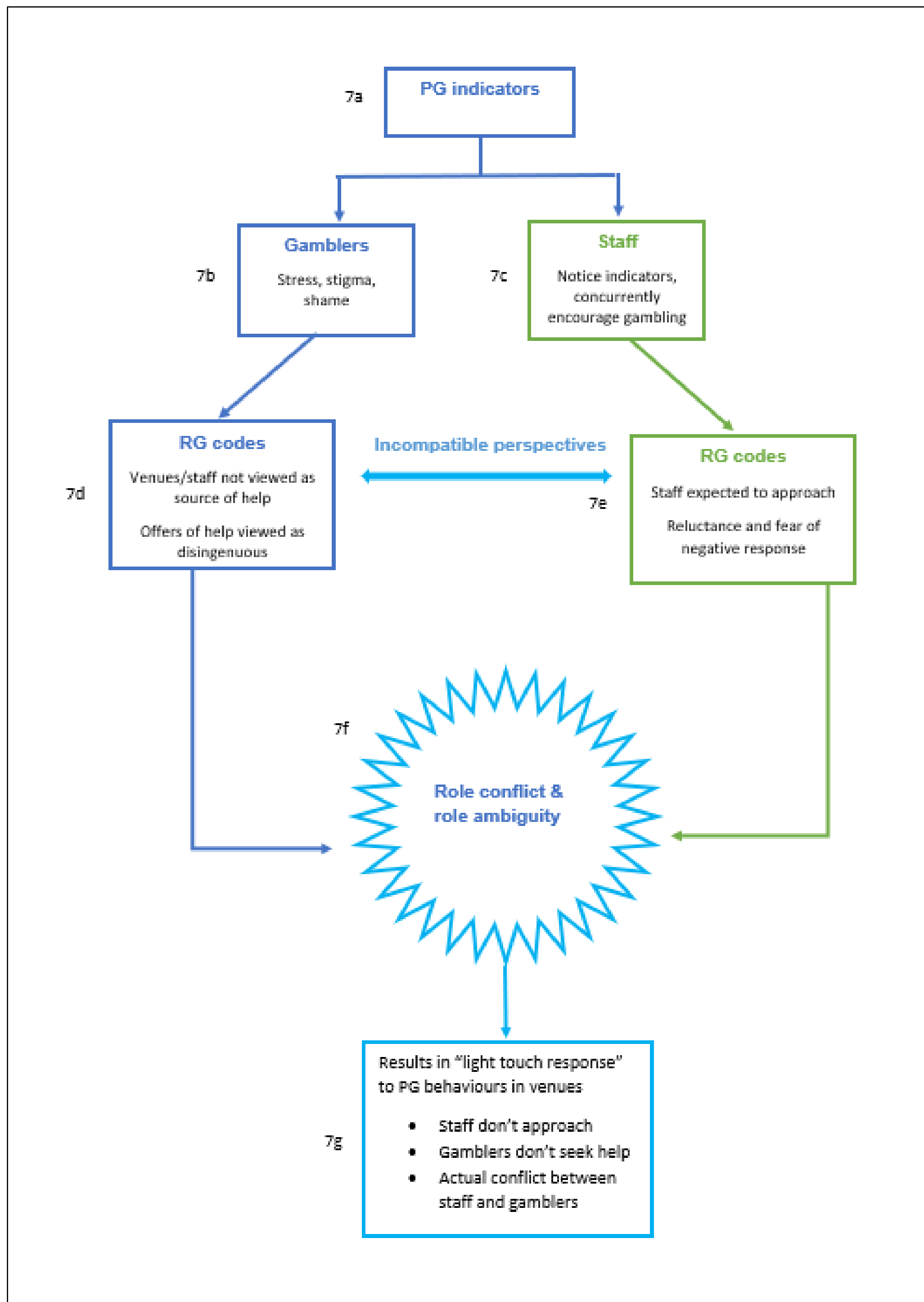

Figure 7. The business versus care paradox leads to role conflict in gambling venues

the staff, as potential sources of help. They perceive the staffs' primary role as facilitating gambling and offers of help by staff are viewed as hypocritical and disingenuous (Fig. 7d). Staff are aware of the paradox and feel conflicted in responding to gambling-related harm whilst maintaining employer profits. In addition, they are conflicted in making judgments about the level of gambling that indicates harm for individual gamblers and are subsequently apprehensive and reluctant to approach them (Fig. 7e). These two perspectives (Figs. 7d-7e) are incompatible, and this leads to role conflict and role ambiguity (Fig. 7f). The result of role conflict and ambiguity is what is described here as a "light touch response" to problem gambling behaviour in venues (Fig 7g).

This is akin to what has been described by other researchers as "light-touch regulation" resulting from conflicts of interest where governments are required to legislate and regulate gambling while being the beneficiaries of gambling profits (Hancock, 2011; Hancock, 2013; Hancock & Smith, 2017b). Due to role conflict and role ambiguity, gamblers do not actively seek help via venue staff. Furthermore, actual conflict between gamblers and staff, such as arguments and altercations, can result if gamblers are approached and feel stigmatised, and perceive staff to be hypocritical and disingenuous.

Role conflict as a consequence of responding to gambling-related harm within interpersonal relationships is presented in Figure 8. When the partner becomes aware of the gambling problem (Fig. 8a) a common strategy is for the gambler to relinquish control of their finances, resulting in a re-allocation of roles (Fig. 8b). Role-reallocation also includes the non-gambling partner taking on the role of monitoring the gambler's movements: the "responsible" person keeping watch over the "irresponsible". This creates additional roles for the partner which can lead to role strain, infantilisation, and chronic hypervigilance as the

partner monitors for gambling behaviour, which they are aware they are not always able to detect (Fig. 8c). The consequences of such role re-allocation can also develop by following advice given by gambling counsellors and other gambling help resources for gamblers and their families (Fig. 8g). This creates role conflict and role ambiguity (Fig. 8d) which leads to further relationship strain (Fig. 8e). A common coping strategy for partners is to withdraw from the gambler and their support network (avoidance coping, Fig. 8f) which creates further

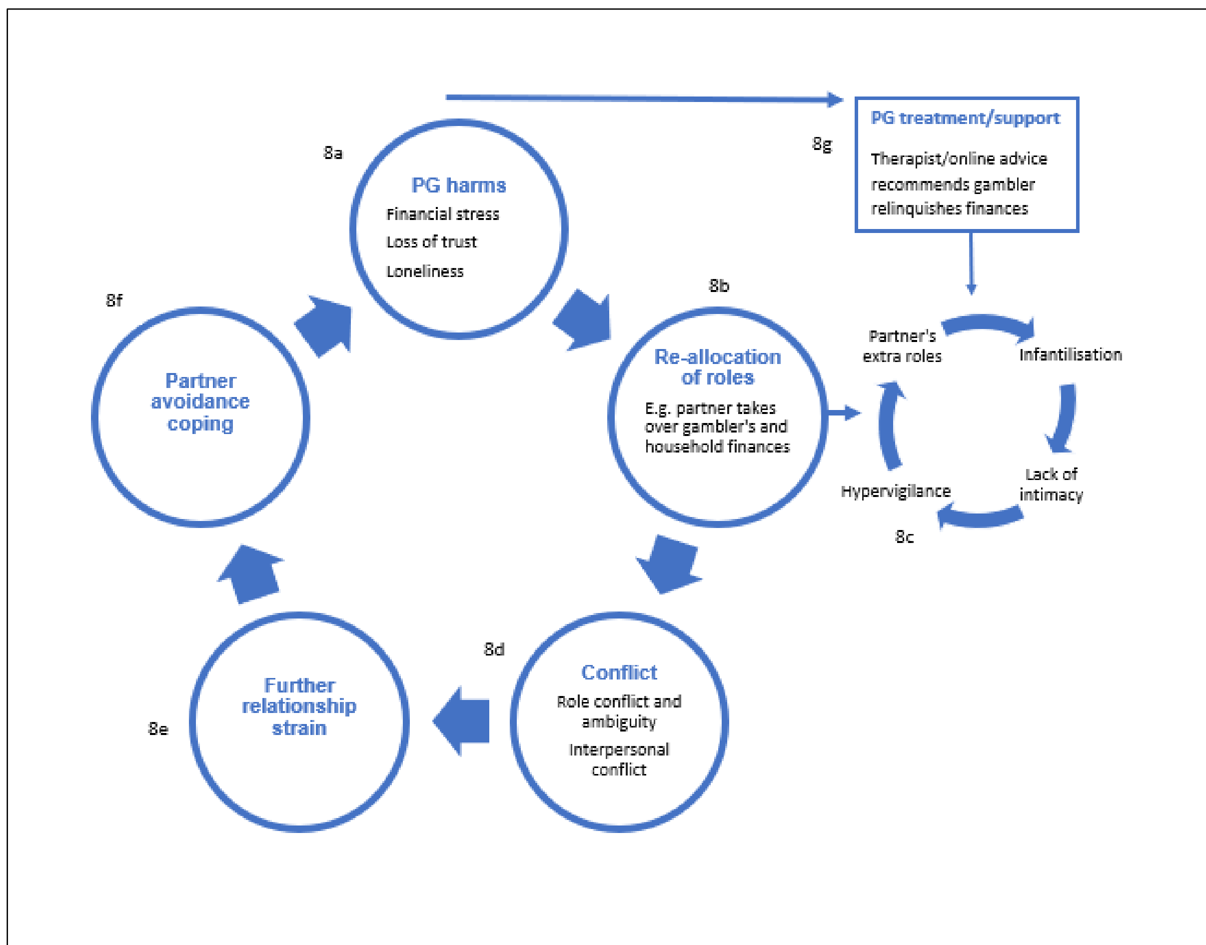

Figure 8. When a solution becomes a problem: role re-allocation and gambling harm minimisation

loneliness, contributing to existing gambling-related harms (Fig. 8a).

In conclusion, the results of the umbrella review indicate that overall, role conflict and role ambiguity harm wellbeing across a range of settings, and the main drivers are incompatibility of roles and a lack of clarity of roles, respectively. These results align with the qualitative research presented in this thesis. The following chapter will summarise the main findings of this research and discuss the implications for policy, practice, and future research.

CHAPTER 9: DISCUSSION AND CONCLUSION

9.1. Introduction

Problem gambling research to date has focused on gamblers with gambling problems who have identified they have a problem and sought help from services to address their gambling. By the time the few gamblers who do seek help approach services, significant harm has been endured by them and their significant others. Overlooking earlier aspects of the help-seeking continuum and the wider context in which gambling takes place, is a significant problem as it limits opportunities to consider early intervention.

This thesis has stepped into the world of the non-help-seeker, and by doing so has provided insights into earlier aspects of gambling-related harm before help is sought. This research has shown that there is a hidden world of gambling-related harm which exists in the space between the development of the gambling problem and the point at which the gambler seeks help. Further, there are opportunities within this space to address gambling-related harms. Essentially, whether it concerns venue-based policies which require staff to intervene when they observe signs of problem gambling or having effective treatments available when gamblers choose to access them, waiting only until gamblers exhibit overt signs of harm or actively seek help is an inadequate response for the gambler, their families, and venue staff. This research has confirmed that significant harms are endured well before individuals with gambling problems seek help, and many do not ever seek formal assistance. This is particularly important given a substantial amount of gambling-related harm occurs among low and moderate risk gamblers (Browne et al., 2016). Considerably more research, policy, and clinical attention need to be focused on earlier aspects of the help-seeking process. While addressing the research aims of this thesis, this chapter will discuss these insights along with alternative approaches to harm reduction and the prevention of gambling-related harm.

The chapter begins by restating the research aims of this thesis (9.1.1.) followed by a synthesis of the key findings across the research undertaken (9.2.). Synthesising the main findings of the three literature reviews and two qualitative studies presented in this thesis led to the emergence of four key findings:

- managing the effects of a person's gambling problem can be hampered by role conflict
- engaging non-help-seeking individuals with gambling problems about their gambling is complicated by perceived stigma
- detecting problem gambling behaviour reliably is difficult
- a disproportionate emphasis on individual accountability for responsible gambling is not working

These themes will be discussed to fulfil study aims 1 and 2. Limitations of this research will then be considered (9.3.) ahead of a discussion of the implications for research, policy, and practice as per study aim 3 (9.4.) followed by concluding comments (9.5.).

9.1.1. Purpose of study

This research aimed to: (a) describe and understand the phenomenon of non-help-seeking in the context of problem gambling; and, based on this understanding, (b) identify barriers and facilitators for how non-help-seeking individuals with gambling problems might be encouraged to seek assistance and opportunities for harm reduction. The contexts of focus in which non-help-seeking were examined were the family of individuals with gambling problems and the gambling venue. The research objectives were as follows:

1. Examine the experiences and responses to people with gambling problems by gambling venue staff
2. Examine the experiences and responses to venue staff offers of help by gamblers
3. Examine the experiences and responses to people with gambling problems by intimate partners
4. Integrate the findings of objectives1 to 3 to make recommendations regarding the practices and strategies of gambling venue staff and intimate partners of people with gambling problems to encourage the gambler to seek help or minimise harm arising from their gambling.

To achieve the research aims and objectives, two literature reviews were conducted to inform two qualitative studies, followed by an umbrella review of role conflict and ambiguity. The qualitative studies involved a series of focus groups and in-depth interviews. The methodology employed was hermeneutical interpretive phenomenology using a Heideggerian philosophical perspective. The first qualitative study (reported in Chapter 6) explored the lived experiences of help-seeking and harm minimisation strategies from the perspectives of gambling venue staff and gamblers with problems. Specifically, the focus was on how gaming room staff and gamblers experienced the delivery of venue-based harm minimisation strategies and the encouragement of help-seeking within the context of gambling venues. The second qualitative study (reported in Chapter 7) examined non-help seeking from the perspectives of individuals living with a partner with a gambling problem who was not seeking help.

Using a hermeneutical interpretive approach in the two qualitative studies enabled the analysis to bring to light the meaning behind the texts provided by participants. For example, the reticence that venue staff expressed about engaging gamblers displaying signs of problem gambling was initially considered to be due to staff's fears that gamblers may be angry after losing money and essentially blame them for their losses. However, through the

hermeneutic process, it became clear that staff's hesitation stemmed from an awareness that their offers of help were likely to be viewed by gamblers as hypocritical and disingenuous due to their conflicting roles, and this was confirmed by the analysis of the gamblers' data. The use of the existential of time, as per Heidegger's phenomenology, allowed the analysis of texts from the partners of gamblers to be interpreted in the context of the temporal frames; past, present, and future, and this led to a deeper understanding of participants' experiences of gambling-related harm. For example, chronic hypervigilance was related to partners' present financial pressures as well as worries about the future, such as having enough money to grow old, and when to start a family.

In addition to the two qualitative studies presented in Chapters 6 and 7, three literature reviews were conducted. Firstly, the empirical literature regarding significant others of people with gambling problems was reviewed systematically, followed by a narrative review of empirical and grey literature concerning the role of gambling venue staff in facilitating the help-seeking process when high-risk gambling behaviours are observed. Finally, as per the iterative nature of this thesis, an umbrella review of the evidence concerning role conflict and role ambiguity was conducted (reported in Chapter 8) and the findings examined with respect to the shared theme, role conflict and ambiguity, across the two qualitative studies presented in Chapters 6 and 7.

9.2. A synthesis of the key findings across the research

9.2.1. Managing the effects of a person's gambling problem can be hampered by role conflict

As reported in the previous chapter (Chapter 8), an umbrella review of the literature concerning role conflict and role ambiguity revealed that almost the entire body of available evidence related to their effects in the workplace and family relationships. Role conflict in the workplace was reported to be among the greatest sources of stress and burnout among

employees across a wide range of workplace settings. Its impact on family relationships was equally harmful, particularly when traditional gender roles were contravened. Given the body of evidence presented in Chapter 8, it is notable that role conflict and role ambiguity have emerged from the current research findings as particularly harmful for gambling venue employees and intimate relationships involving problem gambling. Role conflict and role ambiguity have scarcely been addressed by gambling researchers. This represents an important gap in the literature, particularly given widely disseminated responsible gambling policies that require venue staff to fulfil conflicting roles, and available problem gambling help advice for families which recommends the reallocation of financial administration roles.

Impact of role conflict in gaming venues

Gaming room employee stress resulting from role conflict is itself gambling-related harm that has been largely overlooked by researchers. High staff turnover within the hospitality industry is a well-documented issue and largely attributable to work pressures and stress (AlBattat et al., 2014; Nombeko Felicity, 2019). Moreover, employee turnover has been reported to increase as employees' roles become more specialised and staff require more training (Pranoto, 2011), therefore, it is unsurprising that staff turnover and employee stress are of particular concern in gambling workplaces (Breen et al., 2012). This research has found that role conflict within gaming rooms, which is in part driven by current responsible gambling policies, is an important contributor to employee stress. At the level of gambling venues, staff described a conflict between their dual roles of facilitating the use of gambling machines in the context of a commercial business, and their concurrent role in relation to minimising gambling-related harm to venue patrons. This perceived conflict left them feeling uncertain about how they should act towards gamblers displaying signs of problem gambling; their role was ambiguous. Underpinning the conflict was an ethical, moral conflict of earning their living from working in the venue yet seeing the harm arising from excessive gambling for some patrons, which was experienced by staff as particularly stressful. For staff that described feeling unsupported by upper management, this was an especially difficult

dilemma. Staff also described becoming desensitised to the amount of money patrons spent gambling and the prevalence of problem gambling behaviours in the venue.

In addition to contributing to employee stress, this research has found that role conflict impedes staff from promoting help-seeking among gamblers of concern and, in effect, carrying out their responsible gambling duties. Staff described notable unease about identifying individuals with potential gambling problems, as they felt making what they described as a moral judgement against a patron conflicted with their hospitality role. Considerable ambiguity was expressed by staff regarding which gamblers should be approached, as many appeared to display signs of problem gambling. As such, role conflict was identified as a significant source of stress for venue staff: the conflict and ambiguity that resulted from their responsible gambling obligations were a major contributor to workplace stress.

Given the abundance of evidence related to role conflict and workplace stress, this is not surprising. However, while there has been some discussion of role conflict among venue staff in the gambling literature (Hing & Nuske, 2012a; Tiyce et al., 2013), it is a significant gambling-related harm that has been largely ignored. Further, the little attention role conflict has received has focused on its relationship with employees' stress and burnout (Hing & Nuske, 2012a; Tiyce et al., 2013). To date, it has not been fully considered with regards to its impact on staff's ability to effectively carry out their responsible gambling duties (such as facilitating help-seeking) nor on gamblers' perceptions of such duties. Given the abundance of literature confirming the negative effects of role conflict and ambiguity in the workplace revealed in the umbrella review (reported in Chapter 8), and evidence of its existence among staff in the gambling industry (Hing & Nuske, 2012a; Tiyce et al., 2013), it is surprising that this issue has been largely overlooked by gambling researchers and policy makers. Instead, there appears to have been much greater focus in developing methods to help venue staff detect gamblers with problems (e.g., observable behavioural indicators as reviewed in

Chapter 3) with almost no consideration of the existence and influence of role conflict and ambiguity on staff or gamblers. A responsible gambling framework that emphasises the identification of problem gambling behaviours before action is considered (and as this research has indicated even when it is considered it rarely amounts to effective action), reinforces an assumption that the development of gambling addiction is inevitable and acceptable, and completely ignores earlier opportunities for harm prevention.

While conflicting roles contributes to venue staff apprehension around approaching individuals suspected of having gambling problems, this research has also shown that gamblers concurrently experience an avid awareness of the paradox concerning staff's role in helping to create a hospitable environment to facilitate gambling, while at the same time monitoring for excessive spending on gambling by venue patrons. The findings indicate that gamblers attribute any invitation by venue staff to seek help for their gambling as hypocritical and disingenuous and, as a result, do not view the gambling venue as a location to obtain help-seeking information. Further, gamblers are largely unaware of venue staff's gambling harm reduction training and obligations, which does nothing to help prepare them for any approaches by staff.

While there has been some limited attention concerning the conflict experienced by gambling venue staff, there has been a gap in research concerning gamblers' perspectives regarding this contradiction. The present research has addressed this gap by involving venue staff and gamblers in the research. This enabled the current findings to move beyond those of Hing and Nuske (2011b, 2012a) and Tiyce et al. (2013) by revealing that: (1) the stress experienced by venue staff due to conflicting roles undermined their willingness and confidence in promoting problem gambling harm minimisation and help-seeking among potential at-risk gamblers; and (2) gamblers felt upset and offended when approached by venue staff about their potentially excessive gambling behaviour, due to the perceived hypocrisy. Fear of an unfavourable reception, in particular an angry or even violent reaction,

has been reported to be a key contributor to venue staff's reluctance in initiating uninvited contact around harm minimisation and the encouragement of help-seeking among identified gamblers of concern (Hing & Nuske, 2012a; Hing & Nuske, 2011b). The present research both confirms and extends this knowledge by explaining why gamblers may respond in a hostile manner when approached by venue staff about their level of spending or other behavioural indicators: perceived hypocrisy stemming from role conflict.

To summarise, both venue staff and gamblers alike experienced the "business versus care paradox" brought about by venue staff's conflicting roles, and this hindered opportunities for effective interactions aimed at harm minimisation and the promotion of help-seeking. Findings of the current research suggest that a focus on the identification and intervention specifically with identified gamblers of concern is a particularly unhelpful aspect of the role of venue staff. It is unhelpful as it obstructs effective responding to gamblers with problems and may inadvertently undermine the help-seeking that it is designed to facilitate, and it leads to significant workplace stress for staff. The experience of gambling venue employees concerning exposure to observable gambling-related harms of their patrons has almost been completely ignored by gambling researchers, yet the responsibilities of frontline staff are currently an integral part of responsible gambling policies. The findings of this thesis indicate a re-thinking of the role frontline staff play in addressing problem gambling is necessary.

Impact of role conflict on intimate partner relationships

Role conflict also emerged as a significant gambling-related harm within intimate relationships. The non-gambling partners described taking on numerous additional responsibilities beyond the expectations of their relationship with their partner, to manage the impacts of problem gambling. Conflicting roles harmed relationships. For example, taking over the family finances and closely monitoring the gamblers' spending, including providing the gambler with controlled amounts of "spending money", was described as behaving

parentlike to a naughty child, a “carer” role which was perceived by them as incompatible with being an intimate partner. Such conflict was, in part, related to gendered roles stemming from societal stereotypes evident within the relationship. For example, female partners described feeling particularly uncomfortable controlling their male partners’ finances in situations where the male had been managing the family budget. They described this conflict as a constantly shifting and ambiguous pattern of interaction and behaviour towards the gambler within their relationship.

As identified in Chapter 6, it is common among problem gambling clinical treatment guides (e.g., Battersby et al., 2012; Grant, 2011; Ladouceur & Lachance, 2006; Raylu & Oei, 2010) and guides for families affected by problem gambling (e.g., (Centre for Addictions and Mental Health, 2008; Gamblers Help Victoria, 2020, October 28; O’Conner, 2013) to advise that the gambler’s partner or other trusted person should take over management of the gambler’s finances, with no consideration of the potential problems that may result from this role. While partners and other family members need to protect their financial health from the harms of problem gambling, attention must be given to potential consequences of any re-allocation of roles, particularly given the reported association between problem gambling and family violence (Dowling et al., 2014, 2018; Suomi et al., 2019, 2013; Muelleman, et al., 2002; Svenson et al., 2013). Moreover, role conflict, such as violating traditional gender roles, is associated with male violence towards female partners (Moore & Stuart, 2005).

The term ‘infantalisation’ has been reported explicitly in the context of partners of gamblers with a problem just once in a previous study by Borch (2012) where it was expressed by one female partner. While the term ‘infantilisation’ was not used, in another qualitative study Patford (2009) referred to one participant, a female partner, expressing resentment at having to manage the family’s finances and feeling like she was her male gambling spouse’s mother. The brief mention of this phenomenon in previous literature has been extended in the current research, concerning the negative effects of infantilisation on the dyadic

relationship, in particular, how it disrupted the intimate role, and this experience was shared across the sample among both genders. For example, partners described taking on a parenting role by managing the gamblers' money and scrutinising their movements. Stress arose from the incompatibility of roles: being an intimate partner and being a "parent" of the gambler. In other words, the dyadic relation had changed from partner–partner to parent–child. Such role conflict was reported by some partners as more harmful to their relationship than the actual gambling problem, a juxtaposition also described in the literature by individuals with schizophrenia experiencing over protection by family (González-Torres et al., 2007). Although infantalisation resulting from role conflict has scarcely been reported in the gambling addiction literature, the findings concerning this phenomenon in the current research are also in line with previous research in the area of alcohol addiction (Carter, 1997; Kaufman, 1985).

To summarise, in managing the consequences of problem gambling within intimate partner relationships, couples may adopt new roles within their relationship. Although this is intended to minimise gambling-related harm, it can lead to further stress and actual conflict including intimate partner violence. To avoid conflict some partners of individuals with gambling problems may deliberately enable the gambler, unintentionally reinforcing the pattern of gambling behaviour. The research presented in this thesis has indicated that while partners can play an important role in influencing the gambling behaviour, the solution is much more complicated than advising partners to simply stop enabling the gambler or to take over management of the finances. More nuanced research is needed to understand which strategies can be used by partners to minimise the harms resulting from problem gambling, without producing additional problems.

9.2.2. Engaging non-help-seeking individuals with gambling problems about their gambling is complicated by perceived stigma

In both settings, venues and intimate relationships, stigma was found to be a key barrier to seeking help for gambling-related harms. Partners' concerns about being negatively judged by family and friends created considerable reluctance for them to reach out for help for both themselves and the gambler. Both the gambler and partner kept the problem hidden from other members of the family. The nature of this stigma described by partners, related to worry that both their gambling partner and they, would be negativity evaluated by others: the gambler for having a gambling problem, and themselves for remaining in the relationship with the gambler who, despite their problem, was either in denial or refusing to seek help. Thus, stigma by association, or courtesy stigma (Goffman, 1963), was a key barrier for partners seeking help for both themselves and the gambler.

Gamblers described experiencing significant shame after a relapse of gambling behaviour during attempts at stopping, as described in Chapter 7 within the theme "relapse: a hidden and common experience". They reported they had made numerous attempts to stop gambling and each relapse was perceived as a personal failure which discouraged them from seeking help. Despite high reported relapse rates among individuals recovering from gambling problems (Hodgins & el-Guebaly, 2004; Oakes et al., 2011; Oakes et al., 2019; Oakes et al., 2012; Smith et al., 2013; Suurvali, Hodgins, et al., 2009), gamblers felt they should be able to successfully maintain their gains on their first attempt. As previously discussed in Chapter 2, stigma has been widely reported as a key barrier to help-seeking for gambling-related harm among gamblers and their families. Further, relapse has been reported to increase self-stigma among gamblers with a problem (Hing et al., 2015). The findings of the current research extend this knowledge by offering some insights as to what may be contributing to the experience of stigma around relapse among individuals with gambling problems: gamblers view relapse as a personal failure rather than a step towards recovery, which discourages them from seeking help.

Researchers and clinicians have long known relapse is a common experience during addiction recovery. In Marlatt and Gordon's (1985) influential model of relapse prevention, a distinction is made between lapse and relapse. How an individual responds to an initial lapse has important implications for the likelihood they will either return to an unhelpful pattern of behaviour or learn from their lapse and move forward in the process of recovery. In particular, the abstinence violation effect, which refers to when an individual feels an overwhelming sense of guilt, shame, and failure after breaking a rigid self-imposed rule of abstinence through an initial lapse (Steckler et al., 2013). The current research has suggested that individuals with gambling problems may be unaware of the distinction between lapse and relapse and of the typical pathway of recovery from addiction. Further, there is also recent evidence that gamblers may continue to relapse and resist treatment to avoid facing the despair associated with facing the consequences of their gambling (Oakes et al., 2019). Public health messaging which reminds gamblers that it is normal to make many attempts at quitting before remaining abstinent, similar to the 2013 Quit Victoria anti-smoking advertisement "Never Give Up" (Cancer Council Western Australia, n.d.) may be useful to help promote help-seeking among individuals with gambling problems and their CSOs.

All partners of non-help-seeking gamblers interviewed for this thesis had broached the subject of seeking help with the gambler concerned. Given that the sample comprised partners living with a gambler with a problem who was not seeking help due to denial of their problem or the extent of their problem, or the need for assistance, it is unsurprising that conflict often followed when directly confronting the gambler about their gambling or seeking help; and this was reported by males and females. Fear of additional confrontation which might further damage the relationship was a common experience by non-gambling partners. In addition to fears around damaging the relationship, partners described fears of hostility toward them for suggesting the gambling was harmful and help was required. Domestic violence was described by several female partners who described conflict leading to both

verbal and physical violence after confronting the gambler about their problem. Domestic violence as reported in this study is consistent with other research on the prevalence of family violence in households where a member has a gambling problem (e.g., (Dowling et al., 2016; Suomi et al., 2018; Suomi et al., 2013). Understandably, fear of conflict was a key barrier for partners engaging the gambler in a conversation about help-seeking. Partners expressed considerable anger about the gamblers' lack of acknowledgement of the problem, which was among the greatest sources of their distress. Given the fears expressed by partners and the hidden nature of gambling problems, it would be helpful for services that provide support for individuals experiencing family violence, to routinely screen for gambling problems among their clients' partners or other family members.

9.2.3. Detecting problem gambling behaviour reliably is difficult.

Despite frequent contact with gamblers, venue staff and partners of individuals with gambling problems expressed a lack of confidence in reliably detecting problem gambling behaviour. Chronic hypervigilance was a dominant and common experience by partners and stemmed largely from their inability to reliably detect whether the gambler had gambled or not. Despite being able to observe clear signs of gambling, such as a substantial win or loss reported by the gambler, distinct changes in the gamblers' mood in response to such wins or losses, or large unaccounted lengths of time away from home, an absence of observable indicators did not necessarily mean an absence of gambling. Hence partners worried about possible hidden gambling episodes unknowingly increasing their level of debt, and future gambling episodes, along with ongoing worries about known debts, unpaid bills and negotiating with creditors. Further, as the gamblers within the partnered relationships were not seeking help or were in denial about the existence or extent of their problem, partners were unclear how long they would be performing their carer role and experiencing associated relationship stressors such as the infantilisation of their partner. These issues had a significant impact on the relationships and some partners were seriously considering

separating from their partners. A lack of clarity and certainty about current and future levels of gambling created considerable ambiguity about their future. For instance, partners expressed worries concerning their long-term financial security, when to start a family, and uncertainty about the future of their relationship.

The findings of this research have shown that gambling venue staff confidence in identifying signs of problem gambling does not mean confidence in distinguishing which gamblers have problems. Previous research has indicated that gambling venue staff, despite reporting confidence in their ability to reliably recognise signs of problem gambling (Hing & Nuske, 2011; Hing & Nuske, 2012; Hing, Nuske & Holdsworth, 2013; O'Mahony & Ohtsuka, 2015), feel uncomfortable and reluctant about initiating uninvited contact with identified gamblers of concern (Hing, 2007; Hing & Nuske, 2011b; Hing, Nuske, et al., 2013). While this is consistent with the current research in that venue staff reported trust in their ability to identify observable problem gambling behaviours, staff also indicated a distinct lack of confidence in reliably detecting which gamblers had problems, which brought about ambiguity and stress. This was related to two key issues. First, as discussed earlier in this chapter, they felt tension between facilitating gambling and their awareness of the substantial harms that could result from problem gambling. Second, they felt immense pressure due to their responsibility to distinguish between gamblers with and without problems. Arriving at an assessment that a gambler has a problem requires staff to make a judgment about the gambler's personal circumstances which, for the most part, are largely unknown: for instance, knowing an individual gambler's level of available income or financial and family situation. The current research has highlighted this dilemma and helped to explain the effect it has on staff.

In addition to highlighting the challenges venue staff face in identifying which gamblers have problems, this research has shown that while partners of individuals with gambling problems have the potential to influence help-seeking, their inability to reliably detect gambling

behaviour needs to be considered. The difficulty partners expressed in reliably detecting gambling behaviour presents several challenges when considering how they can encourage the gambler to reduce their gambling and seek help. Unilateral family-based contingency management interventions, namely the Community Reinforcement and Family Training (CRAFT; Meyers et al., 2005) and the Pressures to Change (PTC; Barber & Crisp, 1995) approaches were developed to assist families of substance-addicted individuals who refuse to seek treatment. The interventions are designed to work by teaching CSOs to alter their typical methods of interacting with their substance-using family member. Both CRAFT and PTC approaches place an emphasis on the CSO being able to reliably detect the problem behaviour promptly. This is because instructing families how to cease potentially, albeit unintendedly, rewarding the problem behaviour while positively rewarding non-problem behaviour or an absence of the undesired behaviour is an essential component of both models (Meyers et al., 2005; Barber & Crisp, 1995).

The results of this research have indicated that there may be occasions where the presence of problematic gambling behaviour is clear to partners, potentially allowing them to respond in a way that is guided by unilateral family-based contingency management behavioural models. Additionally, the results indicate partners may also respond in a way which is inconsistent with a family-based contingency management model, for example, by unintentionally reinforcing the gambling. For instance, partners were asked how they typically responded to known gambling behaviour. There were occasions where gambling was reinforced; for example, one partner described how the gambler would purchase gifts for the family or take them out for dinner following a gambling win. The partner explained that they felt they may as well make the most of it, and so accepted the gifts and outings when they were offered. This example demonstrates how the immediate effects of gambling behaviour may be unintentionally reinforced by the family system, despite an acknowledgement of the longer-term harms.

The example given in the previous paragraph is in line with the findings of another recent study which found that, when the partner welcomed the gambler's winnings by showing satisfaction, the gambler felt less remorseful about the gambling and more motivated to continue gambling to reproduce the enjoyable moment (Cote et al., 2020). Similar observations have been made among couples where one partner has an alcohol use disorder (Saatcioglu et al., 2006). For instance, it has been observed that certain benefits to an individual's marriage may result from and maintain drinking. In a study of interactions between married couples where one partner had an alcohol problem, Frankenstein et al. (1985) observed more positive interactions between couples when the drinker was intoxicated compared to when they were sober. Therefore, treatment should involve the re-establishment of these benefits under conditions of sobriety (Frankenstein et al., 1985). Hence, treatment of alcohol use disorders will be more effective if partner behaviours are incorporated into the assessment and intervention (Rotunda et al., 2004). This can be achieved through a careful functional analysis of the drinking behaviour: outlining the triggers of the drinking problem as well as the positive and negative consequences of it and identifying the partner's unintentional role in the maintenance of the person with the cycle of drinking (Hellum et al., 2019).

Given the findings discussed above, it makes theoretical sense that how partners and families of people with gambling problems respond to gambling behaviour has the potential to influence the problem and the person's motivation for help-seeking. Presently there is very little public education for families about problem gambling, and still less in situations where the gambler does not recognise the problem or is resistant to seeking help. Further, as highlighted in Chapter 4, most of the knowledge gained from research on families of individuals with gambling problems has been acquired in situations where the gambler is receiving help, and research on family involvement is largely limited to how families can support gamblers in treatment. Recent qualitative research examining both gamblers with problems and their partners suggested the coping responses utilised by partners could

influence their spouse's gambling behaviour both positively and negatively (Cote et al., 2019).

Although such early data are encouraging, the findings of the current research indicate that, although partners can detect gambling behaviour on occasions, gambling can also occur with no observable indicators. This is highly relevant when considering a contingency management form of intervention as there may be occasions in which gambling occurs undetected and a withdrawal of positive reinforcement does not follow. Such inconsistent or intermittent application of a reinforcement schedule has the potential to maintain the gambling behaviour, or at least render the intervention meaningless to the gambler.

As discussed previously in Chapters 1 and 4, to date, all attempts at adapting the CRAFT intervention for families and or partners of non-help-seeking gamblers have consistently reported low rates of treatment entry, and no differences between treatment entry rates of the intervention and control conditions (Hodgins, Toneatto, et al., 2007; Magnusson et al., 2019a; Makarchuk et al., 2002; Nayoski & Hodgins, 2016). Indeed, Makarchuk et al. (2002) reported that difficulty in identifying precisely when gambling had occurred was the greatest challenge to modifying the CRAFT materials for use with families of non-help-seeking gamblers with problems.

A recently published systematic review of the effectiveness of CRAFT interventions in moving affected individuals into treatment confirmed that the CRAFT interventions for problem gambling studies to date have reported consistently lower treatment entry rates for the gamblers concerned, than substance addiction CRAFT studies, along with no differences between the gambling CRAFT and control conditions (Archer et al., 2020). Archer et al. (2019) also make the point that a lack of reliable detection of non-gambling may be a significant challenge for applying a unilateral CRAFT model to problem gambling. In addition, the authors noted a lack of training of CRAFT training for therapists in the problem gambling

studies as compared to CRAFT trials in the substance addiction literature (Archer et al., 2019), a point similarly made by Roozen et al. (2021) who emphasised the importance of treatment integrity for understanding CRAFT research outcomes. A further point raised by the Archer et al. (2019) review was the lack of an integrated treatment clinic attached to the problem gambling CRAFT interventions. An integrated treatment centre allows immediate access to treatment for treatment refusers who express an interest in help-seeking, and this was reported to be an important contributing component for successful treatment entry among the substance addiction CRAFT studies (Archer et al., 2019).

9.2.4. A disproportionate emphasis on individual accountability for responsible gambling is not working

The research presented in this thesis indicates significant gambling-related harms exist in the hidden world of gamblers with gambling problems who are not seeking help, and there are opportunities to influence help-seeking beyond those which sit with the individual gambler: gambling venue staff and intimate partners of individuals with gambling problems. In other words, gambling behaviour and help-seeking are influenced by social context as well as individual choice. While gambling behaviour and help-seeking are undertaken by individuals, they can be shaped and modified by familial, social, and political factors.

A focus on the gambler

For more than a decade, responsible gambling policy and strategies across numerous jurisdictions have been largely influenced by the Reno Model (Blaszczynski et al., 2004) which is largely based on a paradigm of individualism and the premise that industry can effectively identify and respond to problem gambling. The default position seems to be that all gamblers are deemed responsible until identified as not. That is, there has been almost no empirical attention on what “responsible gambling” entails, to inform public health messaging, akin to, for example, responsible drinking messaging which provides information

about safe levels of alcohol consumption allowing individuals to self-screen (DrinkWise media, 2021). While there has been some attempt at a population level to quantify how much gambling individuals can participate in before harm is endured, using risk curve analyses (Currie et al., 2017; Currie et al., 2006; Currie et al., 2021; Currie et al., 2009), much more attention needs to be placed on the prevention of gambling-related harm from a more holistic public health approach. By approaching gambling problems including issues around help-seeking from an individualistic perspective, it is accepted that individuals are chiefly responsible for the way they gamble and for the development of any harms that may incur, including the development of a gambling addiction and for seeking help when needed.

As discussed in Chapter 3 (which presented a review of corporate responsibility programs in land-based gambling venues), there is growing criticism of viewing gambling problems from a predominately individualistic perspective, and a call for an approach based on consumer protection, public health, and operator duty of care (Abbott, 2020; Hancock & Smith, 2017a, 2017b; The Lancet, 2017). While a move away from an individual-level narrative towards a more holistic perspective is gaining some attention, supporters of the Reno Model for responsible gambling (Blaszczynski et al., 2004) continue to argue in favour of a model which emphasises individual responsibility (Shaffer et al., 2020; Shaffer & Ladouceur, 2021). Shaffer et al. (2021) argue that "assuming personal responsibility is at the centre of personal development" (p. 1075) and go so far as to suggest that measures that encourage individuals to avoid personal responsibility and see their behaviour as a function of external pressures and influence, may impede treatment and recovery from gambling problems (Shaffer et al., 2021). The authors go further and describe the shift away from individual responsibility as a "troubling movement" (p.1072) and make the comment that, while accepting personal responsibility can be a painful process, it is a sign of maturity and personal health.

There would be few who would disagree that with maturity comes acceptance of responsibility, however, in the context of a gambling disorder, it is an overly simplistic statement. Considering findings of the current research, namely, the review of venue-based responsible gambling strategies presented in Chapter 3 and the venue-based qualitative study presented in Chapter 6, it is argued that an emphasis on individual autonomy as an ideal to maintain the responsible gambling status quo, is convenient for industry and those who benefit from industry profits: it helps maintain revenue while promoting an image of social responsibility yet does little to prevent gamblers who have developed problems from further harm or facilitate help-seeking.

While advocating for individual responsibility in the context of problem gambling, Shaffer et al. (2021) fail to acknowledge an important point: gambling disorder is a serious mental illness, with impaired control considered a central psychological construct of the condition (Dickerson, 2006). A widely accepted theoretical model for the development of problem gambling is Blaszczynski & Nower's (2002) Pathways Model. The model accounts for multiple biological, psychological, and ecological determinants and contains three distinct pathways: 'behaviourally conditioned', 'emotionally conditioned', and 'antisocial, impulsivist gamblers.' The behaviourally conditioned pathway poses that gambling problems are precipitated by exposure to gambling (ecological factors such as increased availability and accessibility) followed by the influences of classical and operant conditioning. Intermittent reinforcement is a defining feature of gambling products and can lead to some gamblers being unable to exercise self-control (Battersby et al., 2008; Brevers & Noël, 2013). There is a strong argument that gambling products are inherently dangerous, and providers of such products should be more accountable for the fact that individuals who choose to use their products can develop serious gambling problems. However, the focus of the current research has been the issue of non-help-seeking among gamblers who have developed problems, therefore it is beyond the scope of this thesis to discuss the aetiology of problem gambling.

However, once a gambler has developed a gambling disorder, in which impaired control is a central construct, it is insufficient for harm reduction strategies and the promotion of help-seeking to be largely passive, waiting for the individual with the gambling problem to actively seek help. Particularly given, as argued throughout this thesis, very few individuals who develop gambling problems seek help, and multiple harms are endured preceding help-seeking. While effective clinical treatments must be available and easily accessible for individuals who seek them, more attention should be given to considering opportunities to influence help-seeking and reduce gambling-related harm, which exist beyond those of the individual gambler. The research presented in this thesis indicates that a much greater focus should be placed on the prevention of harm from a public health perspective and the prevention of further harm for individuals who have gambling problems.

Shifting the focus beyond the gambler

Gambling-harm reduction strategies should be multifaceted and consider and address all levels of influence on gambling behaviours. While health interventions are increasingly taking a population-health approach designed to address a range of levels, with a focus on primary prevention (Okechukwu et al., 2014), approaches to gambling harm and help-seeking remain largely individually focussed. The context of families and gambling environments can play an important part in influencing the behaviour of individuals with gambling problems and addressing gambling-related harm. Gambling researchers, policy-makers, human service providers and clinicians, should pay greater attention to social contexts in which gambling occurs. A responsible gambling agenda that frames problem gambling largely as individual choice and, by implication, a personal responsibility, does not adequately consider the importance of social context and broader contextual aspects of problem gambling.

In addition to influencing responsible gambling strategies and policy, an individualistic paradigm has had a major influence on gambling research. Much of the gambling research

concerning harm reduction is focused on treatments for individuals harmed by gambling, with much less attention on the wider environmental and social factors. Researchers and clinicians should consider opportunities to modify the social contexts in which gambling occurs, such as the family: working with families to modify the environment in a way that influences the gambler's behaviour and minimises harm; and gambling venues: such as limiting opening hours, modifying gambling products so they are less harmful, and providing evidence-based harm minimisation information to all gamblers rather than only those identified as already experiencing harm.

Various theoretical models conceptualise human behaviour from a holistic perspective. The Social Cognitive Theory (Bandura, 1998), for example, addresses the socio-structural determinants of health as well as the personal determinants. Bandura (1998) argues that a "comprehensive approach to health promotion requires changing the practices of social systems that have widespread detrimental effects on health rather than solely changing the habits of individuals" (p. 623). While acknowledging the social and psychological influences, social ecological models of health behaviour also emphasise the environment and policy contexts of behaviour (Sallis et al., 2015). Social ecological models contend that multiple levels of factors influence health behaviours and that influences interact across levels, therefore, multi-level interventions are likely needed to change behaviour (Sallis et al., 2015).

A social ecological model of substance addiction considers the individual and sociodemographic factors that influence an individual's decision to engage in substance use (Connell et al., 2010). Viewing addiction from a social ecological framework provides an opportunity to consider harm reduction and health promotion from a more holistic perspective. A recent cross-national study that examined the application of a social ecological model of problem gambling to online gambling found that the online environment and its infrastructure played a major role in problem gambling behaviour (Oksanen et al., 2021). Gambling behaviour takes place in an environment shaped by commercial,

legislative, and cultural factors that influence the availability, accessibility, and promotion of gambling products (Wardle et al., 2019). While problem gambling has been long considered a public health concern, Wardle and colleagues (2019) argue that it must be legislated as a public health problem for policy makers to fully realise a "sustainable funded strategy for preventing harms among the population" (p.1).

One of the first countries to explicitly adopt a public health approach to gambling is New Zealand (Raeburn, 2004) with the New Zealand Government (2003) *Gambling Act 2003* (Cth) mandating an integrated problem gambling strategy focused on public health. The New Zealand Ministry of Health is responsible for implementing this strategy, and from this, five national-level programs have been designed which focus on gambling-related policies, safer gambling environments, problem gambling screening, community awareness and community resilience (Kolandai-Matchett et al., 2018).

To date there has been too great a focus by researchers and policymakers on interventions and treatments when gambling problems arise, at the neglect of non-help-seeking individuals with gambling problems, and gamblers who have not developed problems who may be at risk. The latter of the aforementioned points is important given a higher prevalence of problem gambling found among vulnerable populations such as, for instance, communities experiencing poverty (Hahmann et al., 2021) and electronic gaming machines have been reported to be more highly concentrated in areas of greater socioeconomic disadvantage (Rintoul et al., 2013; Marshall & Baker, 2001). Significantly increasing the focus of problem gambling from a larger context, or the "macro" level, is needed, to provide opportunities for harm prevention, particularly among vulnerable groups.

9.3. Limitations

This research is subject to several limitations which should be considered when interpreting the findings. This research aimed to capture how people made sense of their lived experiences concerning the phenomenon of non-help-seeking in the context of problem gambling, therefore a qualitative methodology was used. In all, across the research project, data was collected via a series of four focus groups and 24 in-depth interviews comprising 55 individuals in total.

Qualitative study 1 limitations (venue staff and gamblers)

All participants were living and working in South Australia, therefore the views expressed may not be representative of other jurisdictions. There are variations within Australia between the States, and internationally, concerning the way gambling harm-minimisation strategies are implemented (as discussed in Chapter 3). Differences in gambling regulatory policies should be considered when interpreting the findings of this study.

Focus group 2 involved venue staff members from different establishments across a metropolitan city. While they were all working in different venues, it cannot be certain that some of them did not know each other. The other three focus groups were composed of participants who were unknown to each other. Ideally, focus groups are composed of people who are unknown to one another, as familiarity can inhibit disclosure (Krueger, 2015). Given the sensitive nature of the topic, this should be considered in relation to the study's findings. As evidenced by the research observer's field notes, there was a substantial of tension at the beginning of focus group 2. It was clear that participants, who were all managers of local hotel gambling venues, were uncomfortable about discussing the issue of problem gambling. The location of this focus group was an important consideration. A boardroom of a hotel central to the city was chosen for both ease of access and because it was an environment that participants would be familiar with, which can help to create an atmosphere of ease, a

prerequisite for open and honest discussion (Tausch & Menold, 2016). As participants began to talk, the discussion flowed more freely, and the content became richer. A further limitation of this qualitative research is the cross-sectional nature of the focus groups, in capturing data at a single point in time. Other research methods such as ethnography (Griffith & Parke, 2008) may be useful to confirm and further these findings.

All gamblers involved in the focus group and follow up in-depth interviews had accessed a gambling help service at some point, and therefore naturally, had identified as having experienced a gambling problem. This allowed the researcher to explore the experiences of gamblers with identified problems, concerning interactions with venue staff around harm minimisation and help-seeking. That said, their views may differ from gamblers with problems who are not actively seeking help or are in denial of their problem, or gamblers with less severe problems. In considering the role of venue staff in help-seeking and identifying gamblers with problems, future research could consider the views of regular gamblers without identified problems, and individuals with gambling problems who are not seeking help.

Qualitative study 2 limitations (partners of gamblers)

In this study, the type of gambling causing problems as described by participants was either land-based electronic gaming machines, horse racing, or both. Lack of further diversity of forms of gambling may serve as a limitation, as the findings, for instance, do not provide any direct knowledge about situations involving internet or smartphone-based gambling. Observable gambling behaviours related to online gambling, such as smartphone-based gambling, may be less noticeable for partners than gambling which involves attending a land-based venue away from home. A more complete understanding of the impacts of other specific forms of gambling, particularly gambling via an electronic mobile device, could be considered by further research using a relevant homogenous sample.

A further limitation of qualitative study 2 is that the sample was composed entirely of white Anglo-Saxon or European Australians. The findings, therefore, do not provide knowledge of the unique experiences of individuals from culturally and linguistically diverse populations. Having said that, ethnic minority populations are a difficult group to access for mental health research (Waheed et al., 2015) and while the sample may not be representative of the wider population, it provides important insights into the hidden world of non-help-seeking which can be built on. Further research that extends the present findings across culturally diverse groups is indicated, particularly given that the findings of the umbrella review inferred role conflict may present unique challenges for non-Western couples, such as the violation of traditional gender roles as discussed in Chapter 8. Further, there are likely other interpersonal contexts that need exploration in future research, for example, where mental health or substance use issues are present. Additionally, populations with socioeconomic disadvantage require more research, particularly given that impact on finances is a key gambling-related harm.

Despite the efforts made to attract a diverse group of participants, just three males responded to the study invitation, all of whom did participate in an in-depth interview. Although there were some shared experiences concerning role conflict between males and females, the sample was more weighted towards females, therefore fewer males' voices were heard. Future research could target male partners of non-help-seeking individuals with gambling problems, and additionally, consider why men living with a partner with a gambling problem, may be especially reluctant to respond to an invitation to share their experience or seek help. Exploring this issue further may provide opportunities to learn more about non-help-seeking.

As all partners involved in this research were in heterosexual relationships, the extent to which these findings apply to more diverse communities is unknown. Further research is needed to understand gambling-related harm among intimate partners from sexually or

gender diverse communities. In addition, it needs to be acknowledged is that while this research explored the issue of non-help-seeking through the experiences partners of non-help-seeking individuals with gambling problems who were still in a relationship with the gambler, family breakdown and divorce rates are high among families affected by problem gambling (Kalischuk et al., 2006; Kourgiantakis et al., 2013). As such, future research should examine non-help-seeking among individuals with gambling problems who are not in an intimate relationship, which may arguably be even more hidden.

A further consideration is that the perspectives of the gambling partner were not examined concerning their perspectives of their partner's role in harm-reduction and help-seeking. For gamblers with problems to be recruited for research and engage in a discussion about their excessive gambling, they would need to have a level of acknowledgement about their problem. The current research aimed to explore the experiences of partners living with a gambler with a problem who was not seeking help, therefore accessing the gambler's perspective was not sought. As mentioned previously in this chapter, there has since been one study published involving matched dyads comprising gamblers with problems and their partners, which indicated spouses were able to influence their gambling partner's gambling behaviour (Cote et al., 2020).

Further to the limitations of the 2 qualitative studies, there are several limitations concerning the literature reviews. Both the systematic review of gambling-related harm and CSOs and the umbrella review of role conflict and ambiguity included peer-reviewed studies written in English. There may have been relevant material in the grey literature that was not included, such as commissioned reports or conference proceedings. A further limitation of the gambling-related harm review is that the samples involved in the selected articles were weighted towards females. There may be differences in how gambling-related harm is experienced by males, an issue that has been raised by the findings of qualitative study 2

(Chapter 7). In addition, despite the structured search strategy used in the literature reviews, there is always the possibility that useful and relevant articles may have been overlooked. The discussion presented in this chapter has moved beyond the description of results reported in the two qualitative studies (chapters 6 and 7), to explore the findings in more detail in relation to insights from the existing literature. The following section will conclude this thesis by presenting recommendations based on the research findings for future research, policy development, and clinical practice, followed by a high-level overview of the research and key findings.

9.4. Implications of research findings

9.4.1 Policy

Concerning gambling venues, shifting the focus away from an individualistic perspective, such as reducing the emphasis on venue staff to make a perceived moral judgment about the gambling behaviours of specific patrons, may improve both the delivery and reception of evidence-based harm reduction gambling information and promote help-seeking. This could be achieved by reconceptualising the role of gaming room staff to provide all gamblers with information about safe gambling, harm minimisation, and available help services. This contrasts with current approaches where the emphasis is placed on venue staff identifying and responding to only those gamblers who are observed to display potential problem gambling behaviours. The provision of harm minimisation and help-seeking information to all gamblers regardless of their level of gambling is more in line with a public health approach as compared to an individualistic health approach.

Corporate social responsibility (CSR) refers to the responsibility a business has for the consequences of its actions in a domain wider than that covered by its profits (Carroll, 1999). Many corporate sectors, such as the alcohol industry, undertake CSR initiatives (Babor &

Robaina, 2013), for instance, sponsorship schemes, public awareness talks, education programs, networking events, and partnerships with government along with voluntary codes of practice for marketing (Yoon & Lam, 2013). There has been growing criticism in recent years with critics highlighting a conflict of interest that exists between the economic objectives of the alcohol industry, which promotes encouraging alcohol consumption, and public health initiatives aimed at reducing alcohol-related harms, which typically means reducing consumption (Mialon & McCambridge, 2018). A recent review of the literature highlighted a distinct lack of evidence that CRS initiatives within the alcohol industry, do anything to reduce harmful drinking. The review concluded that the evidence strongly suggests that CSR initiatives are used by industry to influence the framing of the nature of alcohol-related issues in line with industry interests (Mialon & McCambridge, 2018), with some critics going so far as naming this conflict an "illusion of righteousness" (Yoon & Lam, 2013, p. 1.)

In a similar vein, the findings of the current research have questioned the fundamental notion that gambling venues (which are driven by profits) are suitably able to implement and regulate harm reduction policies. Indeed, a recently published empirical study examining the conflict between responsible gambling programs and the gambling industry's financial interests (Fiedler et al., 2020), concluded that such CSR measures were ineffective due to conflicting interests. Specifically, due to the opposing interests between player protection, and the profits driven by individuals with gambling problems that account for a large share of the total revenue. The authors suggest that CRS programs are effective only when business interests are not at stake, while otherwise mandatory rules with enforcement are required (Fiedler et al., 2020).

Reconceptualising the role of gaming room staff as previously described has implications for how gambling venue staff are trained. Such training should encourage a greater focus on the provision of general education and evidence-based information to all gamblers, rather than

solely engaging with identified patrons of concern. Provision of general education and information to all gamblers may help to eliminate the current perception that staff are required to make moral judgements about a patron's level of risk to harm, which this research indicates, is associated with staff reluctance to approach patrons and refer to an appropriate human service provider. Whereas the provision of information and education as matter of course, would create an environment conducive to the non-judgemental and open exchange of responsible gambling education and support. An expected outcome of adopting this approach across all gaming venues is that all patrons will come to expect a dialogue around responsible gambling practice and available support services at some point. The provision of harm minimisation and help-seeking information in this manner, would be seen as nonintrusive and non-confrontational for both the staff and the patron. A further benefit of such an approach may be a reduction of workplace stress among gambling venue staff employees, who appear to experience high levels of stress (Hing & Breen, 2013), and role conflict has been reported to be a significant contributor to employee stress, more so than role ambiguity and role overload (Michel et al., 2011).

In essence, the paradox between venue staff promoting gambling whilst discouraging excessive gambling is a conflict experienced by both gamblers and staff and appears to be particularly detrimental to effective engagement between the two. This conflict needs to be considered when designing harm prevention and reduction strategies in gambling venues and training gambling venue staff. Reducing role conflict at the level of gambling venues may create an environment more amenable to the effective promotion of harm prevention and help-seeking.

9.4.2. Practice

Two main clinical practice implications are derived from this research concerning working with partners of individuals with gambling problems. The first concerns the difficulty partners

express in reliably detecting gambling behaviour. The second relates to role conflict brought about by strategies implemented to minimise gambling-related harm. An adaption of family-based unilateral interventions using a contingency management approach in the context of unadmitted or non-help-seeking problem gambling, should not rely entirely on the ability of families to deliver a schedule of reinforcement reliant on the detection of gambling behaviour. Instead, emphasis should be placed on reinforcing desired behaviours consistent with help-seeking or harm reduction: behaviours that can be reliably observed and measured. For example, a gambler complaining of a gambling loss to their partner could be viewed as an opportunity to encourage honest communication, which may lead to a discussion about the broader impacts of their gambling and help raise the gambler's awareness of gambling-related harms. Another example may be to schedule an activity that is incompatible with gambling, as included in both the CRAFT and PTC approaches, and focus on positively reinforcing the gambler's engagement in the activity. That is, rather than engaging in the incompatible activity alone as a strategy to minimise gambling behaviour, include clear positive reinforcers for the gambler's engagement. In both examples provided, the desired behaviour is observable and measurable, thus able to be effectively responded to by the family/partner.

Role conflict brought about from a reorganisation of roles intended to minimise gambling-related harm, is an issue that gambling counsellors, health workers, and other human services that provide assistance and advice to individuals and families about problem gambling, should be aware of. Although families must protect themselves from the financial harms associated with problem gambling, advising partners or other family members to take over management of the gambler's finances, should be made with the caveat that it may lead to other problems in the longer term. In particular, concerning intimate relationships, the presence and impact of infantilisation. A restructuring of how the family finances are administered may be necessary, however, being mindful of the potentially negative effects of such a strategy will allow an opportunity for an open conversation about a change in

dynamics within the family. For example, if it is deemed necessary for someone to manage the gambler's finances, the family could consider engaging a professional administrator rather than assign this task to a family member. An awareness of the potential impacts of role reorganisation will allow gambling-help clinicians and health professionals working with individuals with gambling problems and their families, to explore ways to manage or mitigate such effects.

9.4.3. Research

There are three main areas for future research indicated by the findings presented in this thesis. The first area is at the level of gambling venues. This includes further exploration and measurement of role conflict and ambiguity among venue staff, and the proper evaluation of any initiatives implemented in gambling venues concerning the way responsible gambling messaging and strategies, and other CSR measures are delivered. The second area concerns the development and evaluation of unilateral family-based interventions based on contingency management explicitly designed for families/partners of non-help-seeking individuals with gambling problems. The third area involves further exploration of how harm minimisation strategies implemented by gamblers and or their family, impact the problem and the family (e.g., the association between harm reduction strategies and infantilisation).

Evaluation of gambling venue initiatives

The findings of this research suggest that policy initiatives such as corporate responsibility programs implemented at the gambling venue level should be properly evaluated. Implementation of responsible gambling messages could be investigated using qualitative research methodology to examine how gamblers experience such messaging, and if it does lead them to feel less conflicted about offers of help from venue staff. In the same manner, venue staff's experiences could be explored to examine if the presence of such messaging leads them to feel less conflicted, and thereby more confident in disseminating gambling

harm prevention information as a part of their duties. There are several validated psychometric tools designed to measure role conflict and role ambiguity e.g., (Bowling et al., 2017; Siegall, 2000). To date, no study has examined the constructs, role conflict or role ambiguity, among gambling venue staff using quantitative methodology. Doing so would allow researchers to assess the prevalence and levels of role conflict and ambiguity among staff and monitor them as mitigating strategies are introduced. Researchers could then observe if a reduction of role conflict and ambiguity among venue staff leads to lower levels of stress and greater job satisfaction. Further, researchers could then examine any if a reduction in role conflict and ambiguity among staff improves their attitudes towards interacting with gamblers concerning harm minimisation and help-seeking, and ultimately if it leads to more gamblers seeking help. Overall, more attention should be paid to ensuring gambling harm reduction strategies are guided by evidence, which includes proper evaluation. Policy interventions will have little impact if they are not based on evidence (Okechukwu et al., 2014).

Development of specific problem gambling family-based unilateral interventions

Given the low rate of help-seeking among people with gambling problems and the significant harm experienced by their families, more work is needed to assist families to successfully encourage the gambler to seek help. That there have been several, albeit inconclusive, attempts to adapt the CRAFT model for families of individuals with gambling problems (Archer et al., 2020), is encouraging. However, greater attention needs to be focused on the careful adaption of contingency management methods in the context of gambling problems. Gambling therapy services should then promote and offer such interventions to families of unadmitted or treatment refusing individuals with gambling problems, in addition to existing services provided for gamblers who do seek help.

Presence and impact of role re-allocation among families where one member has a gambling problem

As confirmed by the umbrella review presented in Chapter 8, role conflict and ambiguity can be enormously disruptive to interpersonal relationships. Despite it being commonplace for problem gambling treatment protocols to advise that gamblers and their families re-allocate financial administration roles, the issue of role conflict and role ambiguity in the context of families has received little attention from gambling researchers. The phenomenon of infantilisation has been almost completely ignored in the problem gambling literature. Future research could further explore the experience of role-reallocation and infantilisation among family members where the gambler is, in addition to being a partner, a parent, sibling, or child. The issue of caregiving burden among CSOs of people with gambling problems, overall, is an area that has received very little attention. Additionally, the experience of receiving care and the impact of role re-allocation including infantilisation should also be examined from the perspective of the affected gamblers. The experience of infantilisation among gamblers with problems has not been examined to date.

9.5. Conclusion

Significant gambling-related harms are experienced before individuals with gambling problems seek help, and most gamblers with problems never seek help, the problem remaining hidden among themselves and their families. Problem gambling harm reduction strategies and gambling research predominately occur at the point individuals with gambling problems seek help or exhibit overt observable signs of harmful gambling. What this thesis has shown is that waiting for people to actively seek help or exhibit signs of gambling-related harm, is too late. Specifically, a responsible gambling framework that emphasises the identification of problem gambling behaviours before action is considered completely ignores earlier opportunities for harm prevention. Considerably more attention needs to be focused on the policy and practice levels much earlier in the help-seeking process. For example, as

indicated by this research, advising venue staff to provide harm minimisation and help-seeking information to all gamblers regardless of their level of gambling. Further, this thesis has highlighted two potential important pathways to address gambling-related harm and facilitate help-seeking - the gambling venue and families. The thesis has indicated a need for a shift away from a responsible gambling paradigm of individualism to a more holistic multifaceted approach with a focus much earlier in the help-seeking process. It is anticipated that the findings presented may provide an opportunity to rethink the way gambling harm reduction strategies and policies are designed at the level of the venue including a universal information and education approach to all gamblers, and that this research will provide a first step in encouraging researchers to further explore gambling-related harms within families which occur well before gamblers consider seeking help.

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APPENDICES

Appendix 1. Summary of study characteristics and results table: Gambling-related harm as reported by concerned significant others: a systematic review and meta-synthesis of empirical studies

Author, date, country	Title	Method	Participants	Main findings
Balici & Ayranci, 2005, Turkey	Physical violence against women: Evaluation of women assaulted by spouses	Quantitative, cross sectional	135 females attending a forensic medical clinic	79% reported husband had gambling or alcohol problem; 37% reported assault was due to gambling or alcohol problem
Bond et al. 2016, Australia	How a concerned family member, friend or member of the public can help someone with gambling problems: a Delphi consensus study	Delphi consensus study	32 counsellors and researchers; 34 individuals histories pf PG (n=28) or CSOs (n=6)	Guidelines developed as to how CSOs can help problem gamblers. The data suggest that it can be difficult for CSOs to notice signs of PG and that often the only people who would observe the signs are venue staff.
Borch, 2012, Norway	Perceptions of gambling in households - A case study from Norway	Qualitative, discourse analysis	8 couples in which one member was receiving PG group therapy	The concept of Lacan's the Real is used to describe the hidden impacts of problem gambling on households. Modalities of the Real change throughout a household's PG career.
Crisp, Thomas, Jackson & Thomason, 2001, Australia	Partners of problem gamblers who present for counselling: Demographic profile and presenting problems	Quantitative, cross sectional	440 CSOs (partners) who accessed a helpline; 2 thirds female	Most frequently reported problem was interpersonal conflict. Females reported greater financial impact.

Author, date, country	Title	Method	Participants	Main findings
Cunha, Sotero & Relvas, 2015, Portugal	The pathological gambler and his spouse: How do their narratives match?	Qualitative, case study approach	Married couple with male PG, both attending couples counselling due to PG	The PG and spouse's narratives diverged in their perceptions of family functioning with the spouse perceiving greater problems. The gambler had a more positive perspective on gambling-related problems.
Dannon, Lowengrub, Aizer & Cotler, 2006, Israel	Pathological Gambling: Comorbid Psychiatric Diagnoses in Patients and their Families	Quantitative, cross sectional	52 male psychiatric outpatient PGs and their first degree relatives (parents & siblings, n=93) compared with matched controls (n=96)	Significantly higher mood disorders, OCD spectrum disorders and substance abuse disorders were found among first degree relatives of pathological gamblers compared with the control group.
Darbyshire, Oster & Carrige, 2001, Australia	The experience of pervasive loss: Children and young people living in a family where parental gambling is a problem	Qualitative	15 children and adolescents (11 males) of PG parents. Majority recruited through a gambling help service	Most prominent theme was the experience of pervasive loss: loss of the gambling parent, in both physical form and existential sense; e.g. loss of trust of the child's relationship with extended family; loss of security and trust, as well as impact of financial losses.
Dickson-Swift, James & Kippen, 2005, Australia	The experience of living with a problem gambler: Spouses and partners speak out	Qualitative	7 partners (5 women and 2 men) of a PG	8 themes: Availability of gambling, impact on relationship, finances & health, taking responsibility, making sacrifices, guilt & self-blame, isolation.

Author, date, country	Title	Method	Participants	Main findings
Dowling, Smith & Thomas, 2009, Australia	The family functioning of female pathological gamblers	Quantitative	Data taken from treatment study of 53 female PGs. Data included their family: 29 partners and 40 children.	PGs and their partners reported poor adjustment to their dyadic relationships in comparison to a married standardised sample. No difference in psychological functioning between CSOs and a normative standardised sample.
Dowling, Rodda, Lubman & Jackson, 2014, Australia	The impacts of problem gambling on concerned significant others accessing web-based counselling	Quantitative, cross sectional	366 CSOs (91% partners; 84% female) accessing a gambling help telephone service	The most frequently reported impacts were emotional distress and impacts on the relationship. Females displayed significantly higher impacts than males, and physical impacts were significantly positively correlated with age.
Ferland et al., 2008, Canada	Consequences of pathological gambling on the gambler and his spouse	Quantitative, cross sectional	7 heterosexual couples where the male had a gambling problem	Partners and spouses perceived the consequences of the PG as more severe than the gambler.
Goh, Ng, & Yeoh, 2016, Singapore	The family exclusion order as a harm-minimisation measure for casino gambling: the case of Singapore	Qualitative	105 family members (children, parents and spouses). Three quarters of CSOs were female.	Data reported in 2 main themes: financial and non-financial harm. Where the gambler was a parent, the financial impact was much greater. Domestic violence, increased marital conflict and increased stress.
Harrison & Donnelly, 1987, Ireland	A couples group for alcoholics, gamblers and their spouses in recovery: A pilot study	Quantitative, repeated measures	5 couples attending post addiction program, all spouses of addicts were female. 2 PGs.	PG couples scored low on the marital satisfaction scale.

Author, date, country	Title	Method	Participants	Main findings
Heinman, 1987, USA	A comparison: The treatment of wives of alcoholics with the treatment of wives of pathological gamblers	?case study	39 wives of pathological gamblers, 39 wives of alcoholics	Partners of PGs face unique challenges: lack of awareness of the problem and associated anxiety; mood swings by PG for no apparent reason.
Hing, Tiyce, Holdsworth & Nuske, 2013, Australia	All in the family: Help-seeking by significant others of problem gamblers	Quantitative, cross sectional	48 CSOs who contacted a PG help service	CSOs tend to use their own self-management strategies as a first step, with encouraging the gambler to seek help the most common, followed by limiting access to finances. General low awareness of PG services.
Hodgins, Shead & Makarchuk, 2007, Canada	Relationship Satisfaction and Psychological Distress Among Concerned Significant Others of Pathological Gamblers	Quantitative. This data was collected in a previous study (Hodgins, Toneatto, Makarchuk, Skinner & Vincent,2007). Here, the psychological data of the CSOs is presented.	186 CSOs of PGs	Younger female CSOs with younger male gamblers reported greater relationship dissatisfaction. CSOs who reported greater self-efficacy in handling the situation reported less distress and greater relationship satisfaction.
Holdsworth, Nuske, Tiyce & Hing, 2013, Australia	Impacts of gambling problems on partners: partners' interpretations	Qualitative	18 partners and ex-partners of individuals with gambling problems (17 female)	Four themes: financial, emotional, mental and physical, and effects on the relationship.

Author, date, country	Title	Method	Participants	Main findings
Jacobs et al. (1989), USA	Children of problem gamblers	Quantitative	844 high school students	Children of PG parents reported higher levels of substance use and twice the rate of parental divorce of death one parent.
Kourgiantakis, Saint-Jacques & Tremblay, 2017, Canada	Facilitators and Barriers to Family Involvement in Problem Gambling Treatment	Qualitative	11 family dyads (11 couples) with one PG member in treatment	Family involvement in treatment related to better PG outcomes and more positive individual and family functioning.
Krishnan & Orford, 2002, England	Gambling and the family: From the stress-coping-support Perspective	Qualitative & quantitative: cross-sectional interview and questionnaire	16 family members of PGs (mostly parents and partners)	CSOs used controlling strategies to cope with PG, comparable to CSOs of individuals with drug or alcohol problems.
Lee & Rovers, 2008, Canada	Bringing torn lives together again: Effects of the first Congruence Couple Therapy training application to clients in pathological gambling	Quantitative, repeated measures, and qualitative.	24 couples where one was PG (18 males)	Baseline relationship satisfaction for both gamblers and partners was below the normal range for married couples. PG and marital satisfaction improved post CCT.
Lesieur & Rosthchild, 1989, USA	Children of Ga mblers Anonymous members	Quantitative, cross sectional	105 children of PGs in treatment or attending Gamblers Anonymous	Children of parents who had acknowledged their problem, scored better overall on psychological measures than those of parents who had not. Children of multi-problem families scored poorer.

Author, date, country	Title	Method	Participants	Main findings
Lorenz & Shuttlesworth,1983, USA	The impact of pathological gambling on the spouse of the gambler	Quantitative, cross sectional	144 spouses at Gam-Anon, 98% female	First mention in the literature of the need for services for CSOs. Negative impact of PG on CSO's emotional and financial health. CSOs sought a variety of informal help prior to Gam-Anon.
Lorenz & Yaffee, 1988, USA	Pathological gambling: Psychosomatic, emotional and marital difficulties as reported by the spouse	Quantitative, cross sectional	250 female spouses at Gam-Anon	Spouses reported poor physical and psychological health and indicated they did not feel the gambler spent enough time with their children. Mental and physical health positively correlated.
Lorenz & Yaffee, 1989, USA	Pathological gamblers and their spouses: Problems in interaction	Quantitative, cross sectional	151 couples at Gamblers Anonymous and Gam-Anon. All CSOs female.	Spouses reported poor physical (headaches, stomach problems) and psychological (anger, depression) health and indicated they did not feel the gambler spent enough time with their children.
Makarchuk, Hodgins & Peden, 2002, Canada	Development of a brief intervention for concerned significant others of problem gamblers.	Quantitative, RCT	31 CSOs living with or having regular contact with a PG	Elevated psychological distress among CSOs with those living with the PG indicating higher suicidal ideation.
Matthews & Volberg, 2013, Singapore	Impact of problem gambling on financial, emotional and social well-being of Singaporean families	Qualitative	50 family members of PGs (40 female)	Financial, emotional and social impacts presented. Considerable debts, high emotional distress and strained family relationships.

Author, date, country	Title	Method	Participants	Main findings
Mazzoleni, Gorenstein, Fuentes & Travares, 2009, Brazil	Wives of pathological gamblers: Personality traits, depressive symptoms and social adjustment	Quantitative, cross sectional	25 wives of PGs in treatment compared against a matched control	CSOs reported greater marital dissatisfaction, reward dependence, and persistence temperament factors than the non-CSO controls. CSOs did not express greater signs of negative affectivity.
Muelleman, DenOtter, Wadman, Tran & Anderson, 2002, USA	Problem gambling in the partner of the emergency department patient as a risk factor for intimate partner violence	Quantitative, cross sectional	285 women attending an ED	25% of partnered females reported partner violence. Partners of partner violence cases were more likely to be PGs and or problem drinkers.
Nayoski & Hodgins, 2016, Canada	The efficacy of individual community reinforcement and family training (CRAFT) for concerned significant others of problem gamblers	Quantitative, RCT	31 CSOs (90% female) of treatment resistant PGs	CSOs indicated low to moderate relationship happiness. No difference between intervention and control group regarding help-seeking.
Patford, 2007, Australia	The yoke of care: How parents and parents-in-law experience, understand and respond to adult children's gambling problems.	Qualitative	15 parents and parents-in-law of adult children with PG	Adult children's gambling can negatively impact on parents' financially and affect their relationships.
Patford, 2007, Australia	For poorer: How men experience, understand and respond to problematic aspects of a partner's gambling.	Qualitative	13 men whose partner had PG on pokies	Men indicated coping with PG was difficult & stressful, reporting financial losses, domestic conflicts & children's distress
Patford, 2009, Australia	For worse, for poorer and in ill health: How women experience, understand and respond to a partner's gambling problems	Qualitative	23 female partners of problem gamblers; 12 were separated & not living with the gambler	Female partners of PGs are likely to be the victims and enablers of gambling behaviour and may also provide informal control and care.

Author, date, country	Title	Method	Participants	Main findings
Patford, 2007, Australia	Linked lives: Adult children's experiences of late onset parental gambling problems	Qualitative	15 adult children (14 female) of PG parents	PG developed by the parent when the off spring were already adult. PG created significant stress for adult children with some heavily Involved in the provision of informal care.
Romild & Shepherdson, 2013, Sweden	The concerned significant others of people with gambling problems in a national representative sample in Sweden - a 1 year follow-up study.	Quantitative, cross sectional	Population study n = 15000 (63% response rate)	18% population CSOs. CSOs reported poorer mental health, riskier alcohol use, conflict with people close to them and economic stress. Females reported poorer social support, greater legal problems and fear of losing their jobs.
Rychtarik & McGillicuddy, 2006, USA	Preliminary Evaluation of a Coping Skills Training Program for Those with a Pathological Gambling Partner	Quantitative, RCT delayed treatment control	23 (19 female) CSOs living with a problem gambler	Baseline psychological scores for CSOs indicated clinically significant levels of anxiety and depression. Outcomes in favour of intervention group.
Salonen, Alho & Castren, 2015, Finland	The extent and type of gambling harms for concerned significant others: A cross-sectional population study in Finland.	Quantitative	Population based study, n = 4515	19% of respondents identified as CSOs. Males reported close friends with PG and females reported family. Female CSOs indicated experiencing greater harms.
Salonen, Castren, Alho & Lahti, 2014, Finland	Concerned significant others of people with gambling problems in Finland: A cross-sectional population study."	Quantitative, cross sectional	4484 respondents	19% identified as CSOs. Most frequently the person with a gambling problem was a close friend (12.4%). Partners comprised 1.7%. Being a CSO was significantly associated with poor health and wellbeing, regardless of gender.

Author, date, country	Title	Method	Participants	Main findings
Suomi et al,. 2013, Australia	Problem gambling and family violence: family member reports of prevalence, family impacts and family coping	Quantitative and qualitative	120 CSOs surveyed (52% female) & 32 CSOs interviewed (88% female)	52% of CSOs surveyed indicated family violence with females greater victimisation. Violence frequently around money and complicated by alcohol.
Valentine & Hughes, 2010, England	Ripples in a pond: The disclosure to, and management of, problem Internet gambling with/in the family.	Qualitative and quantitative	26 CSOs of internet PGs. CSOs identified by PGs of another study	Problem internet gambling is commonly contained as a secret within families to whom it is disclosed. Disclosure occurred both directly & indirectly. CSO's response to disclosure explored.
Wenzel, Oren & Bakken, 2008, Norway	Gambling problems in the family - A stratified probability sample study of prevalence and reported consequences	Quantitative, cross sectional	Population based study n = 3483	2% identified as CSOs. CSOs were younger and more likely to be female than non-CSOs, and more frequently reported problems with their mental health.
Wurtzburg & Tan, 2011, New Zealand	Sociology of Gambling: Gambling parents' impact on their children in Christchurch	Qualitative	13 parents (10 women) along with their 19 children were recruited from a PG treatment service in New Zealand	Parental problem gambling impacts negatively on the lives of the children.

Appendix 2. Quality ratings for included studies: Gambling-related harm as reported by concerned significant others: a systematic review and meta-synthesis of empirical studies

McMaster University: Critical Review Form – **Quantitative studies**

Study	1. Was the purpose stated clearly?	2. Was relevant background literature reviewed?	3. Was the sample described in detail?	4. Was the sample size justified?	5. Were the outcome measures reliable?	6. Were the outcome measures valid?	7. Intervention was described in detail?	8. Contamination was avoided?	9. Cointervention was avoided?	10. Results were reported in terms of statistical significance?	11. Were the analyses method(s) appropriate?	12. Clinical importance was reported?	13. Drop-outs were reported?	14. Conclusions were appropriate given study methods and results?
Balici et al.	Y	Y	Y	N/A	Y	Y	N/A	N/A	N/A	N/A	Y	Y	N	Y
Crisp et al., 2001	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y
Cunha et al., 2015	Y	Y	Y	N/A	Y	Y	Y	Y	N/A	Y	Y	Y	N	Y
Dannon et al., 2006	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	N	N	Y
Dowling et al., 2009	Y	Y	Y	N/A	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y
Dowling et al., 2014	Y	Y	Y	N/A	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y
Ferland et al., 2008	Y	Y	Y	N/A	Y	Y	N/A	N/A	N/A	Y	Y	Y	Y	Y
Harrison et al., 1987	Y	Y	Y	Y	Y	Y	N	N/A	N/A	N	Y	N	Y	Y
Hodgins et al., 2007	Y	Y	Y	N	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y
Jacobs et al., 1989	Y	N	N	N/A	N/A	N/A	N	N/A	N/A	N	N	Y	N	N
Lesieur et al., 1989	Y	Y	Y	N/A	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y
Lorenz et al., 1983	Y	N	N	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y

Lorenz et al., 1988 Lorenz et al., 1989	Y	Y	Y? N?	N/A	Y	Y	Y	N/A	N/A	N/A	Y	Y	N	Y
Mazzoleni et al., 2009	Y	Y	Y	N/A	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y
Muelleman, et al., 2002	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	Y	Y	Y	N	Y
Nayoski et al., 2016	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y
Rychtarik et al., 2006,	Y	Y	N	N	Y	Y	Y	N/A	N	Y	Y	Y	N	Y
Salonen et al., 2015	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y
Salonen et al., 2016	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y
Salonen et al., 2014	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y
Svensson et al., 2013	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y
Varchon et al., 2004	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y
Wenzel et al., 2008	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N	Y

Notes: Y = yes, N = no, CT = can't tell, NA = not applicable

McMaster University: Critical Review Form – **Qualitative studies** (version 2.0)

Study	1. Was the purpose and/or research question stated clearly?	2. Was relevant background literature reviewed?	3. Was a theoretical perspective identified?	4. Was the process of purposeful selection described?	5. Was sampling done until redundancy in data was reached?	6. Was informed consent obtained?	7. Clear & complete description of: site; participants	8. Role of researcher & relationship with participants	9. Identification of assumptions & biases of researcher	10. Procedural rigour was used in data collection strategies?	11. Data analyses were inductive?	12. Findings were consistent with & reflective of data?	13. Decision trail developed?	14. Process of analysing the data was described	15. Did a meaningful picture of the phenomenon under study emerge?	16. Was there evidence of the four components of trustworthiness: credibility; transferability; dependability; confirmability	17. Conclusions were appropriate given the study finding?	18. The findings contributed to theory development & future practice/research?
Borch, 2012	Y	Y	Y	N	N/A	Y	Y; Y	Y	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Boyd et al., 1970	Y	Y	N	Y	N	N	Y; Y	Y	N	N	Y	Y	Y	N	Y	Y; Y; Y; Y	Y	Y
Cunha et al., 2015	Y	Y	Y	Y	Y	Y	Y; Y	Y	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Darbyshire et al., 2001	Y	Y	N	Y	N/A	Y	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Dickson-Swift et al., 2005	Y	Y	N	Y	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Goh et al., 2016	Y	Y	Y	Y	Y	Y	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Heinman, 1987	Y	N	N	N	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Holdsworth et al., 2013	Y	Y	Y	N	N/A	N	Y; Y	Y	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Kourgiantakis et al., 2017	Y	Y	Y	Y	N/A	Y	Y; Y	Y	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Lesieur, 1979	Y	Y	N	Y	N/A	N	Y; Y	Y	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Mathews et al. 2013	Y	Y	N	N	N/A	N	Y; Y	Y	N	Y	Y	Y	n/a	Y	Y	Y; Y; Y; Y	Y	Y
Patford, 2007a	Y	Y	N	Y	Y	N	Y; Y	N	N	Y	Y	Y	n/a	Y	Y	Y; Y; Y; Y	Y	Y
Patford, 2007b	Y	Y	Y	Y	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Patford, 2007c	Y	Y	Y	Y	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y

Patford, 2009	Y	Y	Y	Y	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Valentine et al., 2009	Y	Y	N	N	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Wurtzburg et al., 2011	Y	Y	Y	Y	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y

Appendix 4. **Mixed Methods** Appraisal Tool (MMAT) – Version 2011

Criteria (MMAT)	Bond et al., 2016	Hing et al., 2013	Krishnan et al., 2002	Lee et al., 2008	Suomi et al., 2013	Makarchuck et al., 2002
Are there clear qualitative and quantitative research questions (or objectives), or a clear mixed methods question (or objective)?	Y	Y	Y	Y	Y	Y
Do the collected data address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	Y	Y	Y	Y	Y	Y
1.1 Are the sources of qualitative data relevant to address the research question?	Y	Y	Y	Y	Y	Y
1.2 Is the process for analysing qualitative data relevant to address the research question?	Y	Y	Y	Y	Y	Y
1.3 I appropriate consideration given to how findings relate to the context?	Y	Y	Y	Y	Y	Y
1.4. Is appropriate consideration given to how findings relate to researchers' influence?	CT	CT	Y	CT	CT	CT
2.1 Is there a clear description of the randomisation (or an appropriate sequence generation)?	NA	NA	NA	NA	NA	Y
2.2 Is there a clear description of the allocation concealment (or blinding where applicable)?	NA	NA	NA	NA	NA	Y
2.3 Are there complete outcome data (80% or above)	NA	NA	NA	Y	NA	Y
2.4 Is there low withdrawal/drop-out (below 20%)?	NA	NA	NA	Y	NA	Y
3.1 Are participants (organisations) recruited in a way that minimises selection bias?	NA	CT	NA	NA	NA	Y
3.2 Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes)?	NA	NA	NA	Y	NA	Y
3.3 In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	NA	NA	NA	NA	NA	Y

3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	NA	NA	NA	Y	NA	Y
4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	Y	Y	Y	Y	Y	Y
4.2. Is the sample representative of the population understudy?	Y	Y	Y	CT	Y	Y
4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?	Y	Y	Y	Y	Y	Y
4.4. Is there an acceptable response rate (60% or above)?	Y	Y	Y	Y	Y	Y
5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	Y	Y	Y	Y	Y	Y
5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	Y	Y	Y	Y	CT	CT
5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	Y	N	CT	Y	N	N

Notes: Y = yes, N = no, CT = can't tell, NA = not applicable

Appendix 3. Summary of study characteristics and results: Gambling-related harm as reported by concerned significant others: an update of the literature

Author, date, country	Design/method	Aim of study	Participants	Main findings	Help-seeking status of gambler
Quantitative					
Afifi et al., 2020 Canada	Cross-sectional	Examine if PG should be defined as an adverse childhood experience	1002 adolescents, 1000 parents	Parental PG related to poorer mental and physical health	Help-seeking status of the gambler not reported
Buchner et al., 2019 Germany	Cross-sectional	Examine if an e-health program could engage CSOs of PG	126 affected others of PGs	e-health is a viable way of engaging CSOs in help for themselves	Help-seeking status of the gambler not reported
Dowling et al., 2018 Australia	Cross-sectional	Examine relationship between parental PG and children's attitudes and behaviours towards gambling	524 university students (56.5% male)	Significant association between parental and offspring PG. Offspring positive attitudes toward gambling an important pathway	Help-seeking status of the gambler not reported
Estevez et al., 2019 Spain	Cross-sectional	Examine differences between family members of people with GD compared with those without	89 CSOs attending therapy and 114 non-CSOs	Family members affected by PG reported poorer mental health	Help-seeking status of the gambler not reported
Forrest & McHale, 2020 UK	Longitudinal	Examine if parental gambling behaviour predicts offspring PG	1058 participants	Parental PG but not gambling participation predicted offspring PG, but was cross-gender only	Help-seeking status of the gambler not reported

Author, date, country	Design/method	Aim of study	Participants	Main findings	Help-seeking status of gambler
Goghari et al., 2020 Canada	Cross-sectional	Investigate the link between childhood trauma and PG among PGs and their first-degree relatives	91 participants (32 PGs, 20 CSOs: 7 parents, 6 children, 7 siblings, and 39 controls)	PGs and CSOs less likely to use task-oriented coping than controls	Help-seeking status of gamblers not reported
Jeffrey et al., 2019 Australia	Cross-sectional	To compare the experience of gambling related harms between gamblers and spouses	5036 participants: gamblers and their spouses	Gamblers and spouses reported a similar quantity of harms, but type of harms differed. Gamblers reported alcohol and health harms; spouses reported emotional and relationship harms	Help-seeking of gamblers not reported
Magnusson et al., 2019 Denmark	Repeated measures RCT	To evaluate the effectiveness of internet-delivered CBT for CSOs of treatment-refusing PGs	100 CSOs of treatment-refusing PGs, mostly partners or parents, majority female (89%) and the gamblers male (95%)	CSO wellbeing improved but gambling behaviour affect was small and inconclusive	Gamblers were not seeking help
Magnusson et al., 2019 Sweden	Cross-sectional	To examine level of agreement re money lost between PG and their CSOs	133 dyads	Fair level of agreement, between the gamblers and their CSOs. The partner CSOs exhibit better agreement than the parent CSOs with regard to the amount of money lost	Gamblers were receiving treatment

Author, date, country	Design/method	Aim of study	Participants	Main findings	Help-seeking status of gambler
Nilson et al., 2020 Sweden	Two parallel-group randomised controlled trial	Compare behavioural couples therapy and CBT for PG	136 dyads (136 PGs and their 136 partners)	No differences between the 2 interventions but more participants in the behavioural couples commenced treatment	Gambler receiving treatment
Nilsson et al., 2018 Sweden	Randomised controlled trial	Compare behavioural couples therapy and CBT for PG	36 dyads (18 PGs and Both their 36 partners)	Both groups improved with no differences between them. CSOs in the behavioural couples groups had lower anxiety and depression post intervention	Gambler receiving treatment
Palmer du Preez et al., 2018 New Zealand	Cross-sectional	To examine prevalence of family violence among PGs and affected others in a help-seeking population	370 gamblers (43.2% female), 84 CSOs (72.6% female partners living with PG) recruited from PG treatment services	65.5% of CSOs reported being victim of family violence; 57.1% CSOs reported perpetrating violence	Gambler and CSO seeking help
Petra, 2020 USA	Cross-sectional	To investigate the importance of coping, social support, and intimate partner violence in the task of dealing with a loved one's addiction	222 intimate partners (96.4% male) of people with addictions (27.9% PG)	CSOs experienced intimate partner violence and psychological distress	Help-seeking status of gambler not reported

Author, date, country	Design/method	Aim of study	Participants	Main findings	Help-seeking status of gambler
Petra, 2020b USA	Cross-sectional	To examine which coping strategies are helpful according to family members of people with substance use or gambling disorder	211 female partners of people with a substance use or gambling disorder (data from previous Petra, 2020 study)	CSOs reported withdrawal coping to be most helpful (focus on own needs and withdraw from partner)	Help-seeking status of gambler not reported
Ponti, Ilari & Tani, 2019 Italy	Cross-sectional	To examine quality of romantic relationships of couples where one partner has a gambling disorder and compare with healthy controls	35 PG couples (29 male gamblers), 45 healthy control couples. All couples heterosexual	PG couples lower relationship quality and higher conflict than controls, particularly among partners of PGs	Gamblers were receiving treatment
Tulloch et al., 2020 Australia	Cross-sectional		N=260 CSOs (49.8% female) from large population survey (N=15,475)	82.3% CSOs reported one or more comorbid stressors and three times the number of stressors than non-CSOs, CSOs reported poorer health and higher rates of smoking	Help-seeking status of gambler not reported
Qualitative					
Cote, Tremblay & Brunelle, 2018 Canada	Semi-structured interviews	Examine coping strategies of partners of PGs	19 participants (8 male-female couples in which one was PG, 2 PGs, 1 partner)	Partners use range of strategies mostly aimed at modifying PG, and improving own well-being	Help-seeking status of the gambler not reported

Author, date, country	Design/method	Aim of study	Participants	Main findings	Help-seeking status of gambler
Cote et al., 2019 Canada	Semi-structured interviews	Examine effectiveness of coping strategies in influencing PG behaviour	Data from previous Cote et al., 2018 study. 19 participants (8 male-female couples in which one was PG, 2 PGs, 1 partner)	Partners' coping strategies can influence PG to both reduce and encourage.	PG treatment-treatment seeking sample
Fulton, 2019 Ireland	In-depth interviews	Examine secretive behaviours related to PG	22 matched pairs of PGs and their CSOs (parents, partners, siblings, adult children, or friends). 86% PGs male,	CSOs were complicate in hiding effects of PG due to social reputation and stigma	Gamblers recruited through PG counselling services and were in recovery
Jarvinen-Tassopoulos, 2020 Finland	Online textual messages, qualitative content analysis	Examine help-seeking behaviours of partner CSOs	40 partners of PGs (38 female)	Barriers to CSO help-seeking were stigma, shame and wanting to keep the family together	Help-seeking status of the gamblers not reported
Klevan, Krane & Wiegand, 2019 Norway	In-depth interviews	To explore how partners of persons with gambling problems experience the family's everyday life, focusing on family relations and parenting	9 female partners of problem gamblers	Loneliness	Help-seeking status of the gamblers not reported
Kourgiantakis, Saint-Jacques & Tremblay, 2018 Canada	interviews	To examine facilitators and barriers to family involvement in PG treatment	11 dyads (22 participants, 13 female, were 8 partner CSOs, 2 children, 1 parent)	Family involvement better outcomes. Facilitators were communication and coping skills, barriers were conflict and substance use	Gamblers and CSOs were receiving treatment

Author, date, country	Design/method	Aim of study	Participants	Main findings	Help-seeking status of gambler
Kwan, Tse & Kackson, 2020 Hong Kong	Interviews	Examine the impact of male PG impact on female spouses	23 female spouse CSOs		Problem gamblers were seeking treatment
Landon, Grayson & Roberts, 2018 New Zealand	In-depth interviews	To explore the impacts of gambling on help-seeking affected others	10 CSOs (sibling, parent, ex-partner, friend, parent), 8 female		
Park & Park, 2019 South Korea	Single case study	To explore marital conflict between a Korean husband and Chinese wife in the condition of living with a mother-in-law	3 participants (married couple and mother-in-law)	Heavy gambling contributed to marital conflict	Help-seeking status of gambler not stated
Tremblay et al., 2018 Canada	interviews	Examine the experiences of PGs and their partners of either individual or couple's treatment	21 gambler and partner couples, majority of partners (87.5%) were female	Both treatments effective though more positive feedback in couples therapy	Gamblers and CSOs receiving treatment
			`		
Mixed methods					
Dowling et al., 2020 Australia	Convergent mixed methods	To examine treatment-seeking PGs recollection of gambling behaviour of their family members during their childhood	97 treatment seeking PGs	Over half reported gambling behaviour within family and around a quarter PG in family during their childhood. Caused parental divorce, financial hardship.	Help-seeking status of gambler not reported

Author, date, country	Design/method	Aim of study	Participants	Main findings	Help-seeking status of gambler
McKeown et al., 2020 UK	Interviews	To explore experiences of carers of people with Parkinson's disease who exhibit impulsive behaviours	13 carers/spouses (12 female)	Spouses reported hypervigilance re finances	Help-seeking status of gambler not reported
Rodda et al., 2019 New Zealand	Convergent mixed methods: descriptive statistics and content analysis	To understand the needs of family members of PGs seeking help via the internet	62 CSOs majority partners (68.9%) along with other relatives and friends, mostly female (91.6%)	CSOs reported wanting interventions that focus on both the gambler and family, CSOs high emotional distress	Help-seeking status of gambler not reported

Appendix 4. Quality ratings for articles: Gambling-related harm as reported by concerned significant others: an update of the literature

McMaster University: Critical Review Form – **Quantitative studies**

Study	1. Was the purpose stated clearly?	2. Was relevant background literature reviewed?	3. Was the sample described in detail?	4. Was the sample size justified?	5. Were the outcome measures reliable?	6. Were the outcome measures valid?	7. Intervention was described in detail?	8. Contamination was avoided?	9. Cointervention was avoided?	10. Results were reported in terms of statistical significance?	11. Were the analyses method(s) appropriate?	12. Clinical importance was reported?	13. Drop-outs were reported?	14. Conclusions were appropriate given study methods and results?
Afifi et al., 2020 Canada	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	Y	Y	Y	N/A	Y
Buchner et al., 2019 Germany	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N/A	Y
Dowling et al., 2018 Australia	Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Y	Y	N/A	Y
Estevez et al., 2019 Spain	Y	Y	Y	Y	Y	Y	NA	N/A	N/A	Y	Y	Y	N/A	Y
Forrest & McHale, 2020 UK	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y
Goghari et al., 2020 Canada	Y	Y	Y	Y	Y	Y	N	N/A	N/A	N	Y	Y	Y	Y

Jeffrey et al., 2019 Australia	Y	N	N	Y	Y	N/A	N	N/A	N/A	N	N	Y	N	N
Magnusson & Nilsson, 2019 Denmark	Y	N	N	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	N/A	Y
Magnusson et al., 2019 Sweden	Y	Y	Y? N?	N/A	Y	Y	Y	N/A	N/A	N/A	Y	Y	N	Y
Nilson et al., 2020 Sweden	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y
Nilsson et al., 2018 Sweden	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Palmer du Preez et al., 2018 New Zealand	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	Y	Y	Y	N/A	Y
Petra, 2020 USA	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	Y	Y	Y	N/A	Y
Petra, 2020b USA	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	Y	Y	Y	N/A	Y
Ponti, Ilari & Tani, 2019 Italy	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	Y	Y	Y	N/A	Y

Notes: Y = yes, N = no, CT = can't tell, NA = not applicable

McMaster University: Critical Review Form – **Qualitative studies** (version 2.0)

Study	1. Was the purpose and/or research question stated clearly?	2. Was relevant background literature reviewed?	3. Was a theoretical perspective identified?	4. Was the process of purposeful selection described?	5. Was sampling done until redundancy in data was reached?	6. Was informed consent obtained?	7. Clear & complete description of: site; participants	8. Role of researcher & relationship with participants	9. Identification of assumptions & biases of researcher	10. Procedural rigour was used in data collection strategies?	11. Data analyses were inductive?	12. Findings were consistent with & reflective of data?	13. Decision trail developed?	14. Process of analysing the data was described	15. Did a meaningful picture of the phenomenon under study emerge?	16. Was there evidence of the four components of trustworthiness: credibility; transferability; dependability; confirmability	17. Conclusions were appropriate given the study finding?	18. The findings contributed to theory development & future practice/research?
Cote et al., 2019 Canada	Y	Y	N	Y	N/A	Y	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Fulton, 2019 Ireland	Y	Y	N	N	Y	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Jarvinen-Tassopoulos, 2020 Finland	Y	Y	N	Y	N/A	CT	Y; Y	Y	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Klevan, Krane & Wiegand, 2019 Norway	Y	Y	Y	Y	CT	Y	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Kourgiantakis, Saint-Jacques & Tremblay, 2018	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y; Y;Y;Y;	Y	Y
Kwan, Tse & Kackson, 2020 Hong Kong	Y	Y	N	Y	Y	Y	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Landon, Grayson & Roberts, 2018 New Zealand	Y	Y	Y	N	N/A	Y	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y

Park & Park, 2019 South Korea	Y	Y	Y	Y	N/A	Y	Y; Y	Y	Y	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y
Tremblay et al., 2018 Canada	Y	Y	Y	Y	N/A	N	Y; Y	N	N	Y	Y	Y	Y	Y	Y	Y; Y; Y; Y	Y	Y

Mixed Methods Appraisal Tool (MMAT) – Version 2011

Criteria (MMAT)	Cote, Tremblay & Brunelle, 2018 Canada	Dowling et al., 2020 Australia	McKeown et al., 2020 UK	Rodda et al., 2019 New Zealand
Are there clear qualitative and quantitative research questions (or objectives), or a clear mixed methods question (or objective)?	Y	Y	Y	Y
Do the collected data address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	Y	Y	Y	Y
1.1 Are the sources of qualitative data relevant to address the research question?	Y	Y	Y	Y
1.2 Is the process for analysing qualitative data relevant to address the research question?	Y	Y	Y	Y
1.3 I appropriate consideration given to how findings relate to the context?	Y	Y	Y	Y
1.4. Is appropriate consideration given to how findings relate to researchers' influence?	N	CT	CT	CT
2.1 Is there a clear description of the randomisation (or an appropriate sequence generation)?	NA	NA	NA	NA
2.2 Is there a clear description of the allocation concealment (or blinding where applicable)?	NA	NA	NA	NA
2.3 Are there complete outcome data (80% or above)	NA	NA	NA	NA
2.4 Is there low withdrawal/drop-out (below 20%)?	NA	NA	NA	NA
3.1 Are participants (organisations) recruited in a way that minimises selection bias?	CT	NA	CT	NA
3.2 Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes)?	NA	NA	NA	NA
3.3 In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	NA	NA	NA	NA

3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	NA	NA	NA	NA
4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	Y	Y	Y	Y
4.2. Is the sample representative of the population understudy?	Y	Y	Y	Y
4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?	Y	Y	Y	Y
4.4. Is there an acceptable response rate (60% or above)?	Y	Y	Y	Y
5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	Y	Y	Y	Y
5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	Y	Y	Y	Y
5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	Y	Y	N	CT

Notes: Y = yes, N = no, CT = can't tell, NA = not applicable

Appendix 5. Ethics approval qualitative study 1.

Office for Research
Flinders Medical Centre / The Flats F6/F8
Flinders Drive, Bedford Park SA 5042
Tel: (08) 8204 6453
E: Health.SALHNOfficeforResearch@sa.gov.au

Government of South Australia
SA Health
Southern Adelaide Local Health Network

Amendment to ethics application approved

You are reminded that this letter constitutes ethical approval only for this amendment. If you are waiting on Site Specific Assessment (SSA) authorisation for your study, you must not commence this research project at any public Health site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

17 June 2016

Professor Peter Harvey
Margaret Tobin Centre
Flinders Medical Centre
BEDFORD PARK SA 5042

Dear Professor Harvey

The Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC EC00188) have reviewed and provided ethical approval for this amendment which appears to meet the requirements of the *National Statement on Ethical Conduct in Human Research.*

Application Number: OFR # 402.13 - HREC/13/SAC/258

Title: The Statewide Gambling Therapy Service longitudinal patient data tracking project; a quality improvement programme

Chief Investigator: Dear Professor Harvey

Approval date: 16 June 2016

This amendment approval does not alter the current SAC HREC approval period for the study: 09 October 2013 to 09 October 2016

Public health sites approved under this application: Flinders Medical Centre

The below documents have been reviewed and approved:

- Cover Letter dated 22 April 2016
- Project Amendment Application form dated 22 April 2016
- General Research Application form v4 dated 15 April 2016
- Participant Information Sheet – Consumer Voice Participants
- Participant Information Sheet – Gaming Venue and Help Service Staff
- Hotels Association Support Letter for Focus Groups dated 26 April 2016
- Letter of Invitation dated 22 April 2016
- Focus Group Topics

TERMS AND CONDITIONS OF ETHICAL APPROVAL
As part of the Institution's responsibilities in monitoring research and complying with audit requirements, it is essential that researchers adhere to the conditions below and with the *National Statement chapter 5.5.*

Appendix 6. Information and consent forms qualitative study 1: counselling and venue staff

Appendix 6. Staff: venues and gambling help services information and consent forms

FMC Office 8204 6982, **Salisbury** 8182 4911& **Port Adelaide** 8240 0522

Participant Information Sheet: Focus groups with gaming venue and gambling help serivce staff

Name of Organisation:

The Statewide Gambling Therapy Service (SGTS), in collaboration with the Flinders Centre for Gambling Reserch, Flinders University

Title of the project:

The Statewide Gambling Therapy Service (SGTS) longitudinal patient data tracking project; a quality improvement programme: Focus groups with gaming venue staff, gambling help services and problem gamblers

Aims of the project:

This project is an additional part of the larger SGTS program. We are interested in learning more about the pre-treatment seeking world of problem gamblers. We are particularly interested how gaming venue staff respond to patrons of concern and refer to gambling help services. In order to achieve this we are seeking the perspectives of gaming venue staff, gambling help services and problem gamblers. This information will assist us to develop recommendations aimed at improving the way we identify, approach and refer gaming venue patrons to gambling help services who are displaying signs of problematic gambling behaviour.

Invitation to participate:

As someone who works at a gaming venue, gambling help service you are invited to take part in an in-depth interview we are conducting to help us better understand the pre-treatment seeking world of problem gamblers.

Summary of procedures:

You are invited to attend an individual interview which will last for up to one hour in a private meeting room at the Margaret Tobin Centre, Flinders University Bedford Park Campus or another suitable private place. Key themes that will be addressed will include but not be limited to gamblers' interactions with venue staff and referrals from venues to gambling help services. The interviews will be conducted by one of the researchers, Ben Riley or Simone Orlowski.

The interview will be audio recorded if consent is provided and analysed by the researchers. The recordings will be kept in a secure location and will not be available to anyone outside the research team. If consent to record is not provided detailed notes will be taken instead. Any transcripts made of the recordings will be de-identified which means your idendity will remain anonymous and you will not be identifiable by your comments.

Commitments:
Each participant will be invited to take part in an individual face to face interview which will last up to one hour.

Benefits:

There will be no direct benefit for participants. The study will assist researchers to better understand the pre-treatment seeking world of problem gamblers.

What will happen to me at the end of the study?

There will be no further involvement required following the interview.

Will I be identifiable by being involved in this study?
All records containing personal information will remain confidential and no information which could lead to your identification will be released, except as required by law.

Are there any risks or discomforts if I am involved?

There are no perceived risks to clients as a result of this study.

Compensation:

If you suffer injury as a result of participation in this treatment and research programme, compensation might be paid without litigation, however, such compensation is not automatic and you may have to take legal action to determine whether you should be paid.

Confidentiality:

All records containing personal information will remain confidential and no information which could lead to your identification will be released, except as required by law.

Publication:

The findings of this study may be published in scientific journals at a later date. It is possible that the results may be published for commercial, scientific or other reasons. There will be no reference in such reports to any individual participant in the SGTS treatment or research programme.

Withdrawal:

Participatants are free to withdraw from the study at any time.

Contact:

Please contact Professor Peter Harvey (08 84042541) if you have any questions about your involvement in the study.

Complaints:

The processes and procedures of this study have been reviewed by the Southern Adelaide Clinical Human Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant or should you wish to make a confidential complaint, you may contact the Executive Officer, SAC HREC at the Flinders Medical Centre (8204 6453) or email research.ethics@health.sa.gov.au.

CONSENT TO PARTICIPATION IN RESEARCH

I, ...
(first or given names) *(last name)*

give consent to my involvement in the research project

....
(short title)

I acknowledge the nature, purpose and contemplated effects of the research project, especially as far as they affect me, have been fully explained to my satisfaction by

....
(first or given name) *(last name)*

and my consent is given voluntarily.

I acknowledge that the detail(s) of the following has/have been explained to me, including indications of risks; any discomfort involved; anticipation of length of time; and the frequency with which they will be performed, eg

- electronic recording of the interview and or detailed notes recorded

I have understood and am satisfied with the explanations that I have been given.

I have been provided with a written information sheet.

I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over the age of 18 years.

I acknowledge that I have been informed that should I receive an injury as a result of taking part in this study, I may need to start legal action to determine whether I should be paid.

Signature of Research Participant : .... Date: ....

I, ... have described to ....

the research project and nature and effects of procedure(s) involved. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature: .... Date: ....

Status in Project:

Appendix 7. Information and consent forms qualitative study 1: Gamblers

Appendix 7. Information and consent forms for individuals with lived experience of problem gambling

FMC Office 8204 6982, **Salisbury** 8182 4911& **Port Adelaide** 8240 0522

Participant Information Sheet: Focus groups with gaming venue and gambling help serivce staff

Name of Organisation:

The Statewide Gambling Therapy Service (SGTS), in collaboration with the Flinders Centre for Gambling Reserch, Flinders University

Title of the project:

The Statewide Gambling Therapy Service (SGTS) longitudinal patient data tracking project; a quality improvement programme: Focus groups with gaming venue staff, gambling help services and problem gamblers

Aims of the project:

This project is an additional part of the larger SGTS program. We are interested in learning more about the pre-treatment seeking world of problem gamblers. We are particularly interested how gaming venue staff respond to patrons of concern and refer to gambling help services. In order to achieve this we are seeking the perspectives of gaming venue staff, gambling help services and problem gamblers. This information will assist us to develop recommendations aimed at improving the way we identify, approach and refer gaming venue patrons to gambling help services who are displaying signs of problematic gambling behaviour.

Invitation to participate:

As someone who has experience gambling in gaming rooms, you are invited to take part in an in-depth interview we are conducting to help us better understand the pre-treatment seeking world of problem gamblers.

Summary of procedures:

You are invited to attend an individual interview which will last for up to one hour in a private meeting room at the Margaret Tobin Centre, Flinders University Bedford Park Campus or another suitable private place. Key themes that will be addressed will include but not be limited to gamblers' interactions with venue staff and referrals from venues to gambling help services. The interviews will be conducted by one of the researchers, Ben Riley or Simone Orlowski. For your involvement you will receive an honararium by way of a $40 shopping gift card.

The interview will be audio recorded if consent is provided and analysed by the researchers. The recordings will be kept in a secure location and will not be available to anyone outside the research team. If consent to record is not provided detailed notes will be taken instead. Any transcripts made of the recordings will be de-identified which means your idendity will remain anonymous and you will not be identifiable by your comments.

Commitments:
Each participant will be invited to take part in an individual face to face interview which will last up to one hour.

Benefits:

There will be no direct benefit for participants. The study will assist researchers to better understand the pre-treatment seeking world of problem gamblers.

What will happen to me at the end of the study?

There will be no further involvement required following the interview.

Will I be identifiable by being involved in this study?
All records containing personal information will remain confidential and no information which could lead to your identification will be released, except as required by law.

Are there any risks or discomforts if I am involved?

There are no perceived risks to clients as a result of this study.

Compensation:

If you suffer injury as a result of participation in this treatment and research programme, compensation might be paid without litigation, however, such compensation is not automatic and you may have to take legal action to determine whether you should be paid.

Confidentiality:

All records containing personal information will remain confidential and no information which could lead to your identification will be released, except as required by law.

Publication:

The findings of this study may be published in scientific journals at a later date. It is possible that the results may be published for commercial, scientific or other reasons. There will be no reference in such reports to any individual participant in the SGTS treatment or research programme.

Withdrawal:

Participatants are free to withdraw from the study at any time.

Contact:

Please contact Professor Peter Harvey (08 84042541) if you have any questions about your involvement in the study.

Complaints:

The processes and procedures of this study have been reviewed by the Southern Adelaide Clinical Human Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant or should you wish to make a confidential complaint, you may contact the Executive Officer, SAC HREC at the Flinders Medical Centre (8204 6453) or email research.ethics@health.sa.gov.au.

CONSENT TO PARTICIPATION IN RESEARCH

I, ...
(first or given names) *(last name)*

give consent to my involvement in the research project

....
(short title)

I acknowledge the nature, purpose and contemplated effects of the research project, especially as far as they affect me, have been fully explained to my satisfaction by

....
(first or given name) *(last name)*

and my consent is given voluntarily.

I acknowledge that the detail(s) of the following has/have been explained to me, including indications of risks; any discomfort involved; anticipation of length of time; and the frequency with which they will be performed, eg

- electronic recording of the interview and or detailed notes recorded

I have understood and am satisfied with the explanations that I have been given.

I have been provided with a written information sheet.

I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over the age of 18 years.

I acknowledge that I have been informed that should I receive an injury as a result of taking part in this study, I may need to start legal action to determine whether I should be paid.

Signature of Research Participant : .... Date: ....

I, ... have described to ....

the research project and nature and effects of procedure(s) involved. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature: .... Date: ....

Status in Project:

Appendix 8. Qualitative study 1 interview questions

Appendix 8. Interview Questions Qualitative Study 1

Focus group 1 & 3 individuals with lived experience of problem gambling

1. Tell us about your journey of help-seeking
2. Tell us about your experiences with the Gambling Help Line (GHL)
3. What is your experience with venue staff interacting with you around referring to Gambling Help Services (GHS)?
4. What is your experience with available gambling help support and help materials in the venue?
5. Were there people along the way that you talked to who suggested you see someone, or who could have suggested this to you?

Focus Group 2 Venue staff

1. What is your experience interacting with, responding to and referring patrons of concern to GHS?
2. What is your experience with available gambling help support and help materials in the venue (including GHL)?
3. Discuss your experience interacting with patrons from Culturally and Linguistically Diverse (CALD) backgrounds with respect to referring to GHS

Appendix 9. Ethics approval qualitative study 2.

Note: this approval included both the CSO interviews and another study in a prison setting separate to this thesis

Appendix 9. Ethics approval for qualitative study 2.

Southern Adelaide Clinical Human Research Ethics Committee

Government of South Australia
Southern Adelaide Health Service

02 April 2015

Dear Professor Harvey

This is a formal correspondence from the Southern Adelaide Clinical Human Research Ethics Committee. Whilst this official title of the committee has changed the committee is still properly constituted under AHEC requirements with the registration number EC00188. This committee operates in accordance with the "National Statement on Ethical Conduct in Human Research (2007)." This department only uses email correspondence for all documents unless prior arrangements have been made with the manager. No hard copy correspondence will be issued.

Application Number: 402.13

Title: The Statewide Gambling Therapy Service longitudinal patient data tracking project; a quality improvement programme

Chief Investigator: Professor Peter Harvey

Approved public heath sites: Flinders Medical Centre / Statewide Gambling Therapy Service – Salisbury and Pt Adelaide

The Issue: The Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC) has approved the project amendment, and your project may now incorporate these amendments into your research. The approval extends to the following documents/changes:

- Cover Letter dated 14 January 2015
- Project Amendment Form v3 dated 03 January 2015
- General Research Application form v4 dated 15 January 2015 (tracked)
- SGTS Client Participant Information Sheet (tracked)
- SGTS Consent to Participation in Research Adults Form v3 dated October 18 2013
- The EIGHT Screen questionnaire
- Letter of support from Cadell Training Centre management
- Letter of support from Adelaide Pre-release Centre and Adelaide Women's Prison dated 10 December 2014
- Letter of support from Mobilong Prison no date

This amendment approval does not alter the current SAC HREC approval period for the study: 09 October 2013 – 09 October 2016

Please read the terms and conditions of ethical approval below, as researchers have a significant responsibility to comply with reporting requirements and the other stated conditions.

For example, the implications of not providing annual reports and requesting an extension for research prior to approval expiring could lead to the suspension of the research, and has further serious consequences.

Please retain a copy of this approval for your records.

Flinders Medical Centre

The Flats G5 – Rooms 3 and 4

Flinders Drive, Bedford Park SA 5042

T: 08 8204 6453

E:Research.ethics @health.sa.gov.au

TERMS AND CONDITIONS OF ETHICAL APPROVAL
Final ethical approval is granted subject to the researcher agreeing to meet the following terms and conditions.

As part of the Institution's responsibilities in monitoring research and complying with audit requirements, it is essential that researchers adhere to the conditions below.

Researchers have a significant responsibility to comply with the *National Statement 5.5.* in providing the SAC HREC with the required information and reporting as detailed below:

1. **Compliance** with the *National Statement on Ethical Conduct in Human Research* (2007) & the *Australian Code for the Responsible Conduct of Research* (2007).
2. To **immediately report to SAC HREC** anything that may change the ethical or scientific integrity of the project.
3. **If University personnel are involved in this project,** the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements.
4. **It is the policy of the SAC HREC not to provide signed hardcopy or signed electronic approval letters**, as our office is moving to electronic documentation. The SAC HREC office provides an unsigned electronic PDF version of the study approval letter to the Chief Investigator/Study Manager via email. These email approvals are generated via the email address research.ethics@health.sa.gov.au which can be linked back to the SAC HREC.
5. **Report Significant Adverse events (SAE's)** as per SAE requirements available at our website.
6. **Submit an annual report on each anniversary of the date of final approval** and in the correct template from the SAC HREC website.
7. **Confidentiality** of research participants MUST be maintained at all times.
8. A copy of the **signed consent form** must be given to the participant unless the project is an audit.
9. Any **reports or publications derived from the research** should be submitted to the Committee at the completion of the project.
10. All requests for **access to medical records** at any SALHN site must be accompanied by this approval email.
11. To **regularly review the SAC HREC website** and comply with all submission requirements, as they change from time to time.
12. The researchers agree to use **electronic format** for all correspondence with this department.
13. Researchers are reminded that **all advertisements/flyers** need to be approved by the committee, and that no promotion of a study can commence until final ethics and executive approval has been obtained. In addition, all media contract should be coordinated through the FMC media unit.

Yours sincerely

Anna Panteldis
Administration Officer, SAC HREC

On behalf of

Professor David Gordon
Chair, SAC HREC

Appendix 10. Information and consent forms qualitative study 2

Appendix 10. Information and consent form for partners of non-help-seeking individuals with gambling problems

FMC Office 8204 6982, **Salisbury** 8182 4911& **Port Adelaide** 8240 0522

SGTS Client Participant Information Sheet: In-depth qualitative interviews with partners of non-help seeking problem gamblers

Name of Organisation:

The Statewide Gambling Therapy Service (SGTS)

Title of the project:

The Statewide Gambling Therapy Service (SGTS) longitudinal patient data tracking project; a quality improvement programme: In-depth qualitative interviews with partners of non-help seeking problem gamblers

Aims of the project:

This project is an additional part of the larger SGTS program. We are interested in learning more about the experiences of individuals who live with a partner who has a gambling problem and is not actively seeking help. This information will assist us to develop effective interventions for families of non-help-seeking problem gamblers.

Invitation to participate:

As someone living with a partner who has a gambling probem and is not actively seeking help for their problem, you are invited to take part in a series of interviews we are conducting to help us better understand the effects of problem gambling on families.

Summary of procedures:

Participants of the in-depth interviews will be asked to share information about their experience of living with a partner who has a gambling problem and who is not actively seeking help. The interviews will be conducted individually and face to face with a senior SGTS therapist at one of the SGTS offices and run for approximately one hour. Key themes that will be will addressed include, but will not be limited to:

- the day-to-day experiences of partners who live with a spouse with a gambling problem
- the social and interpersonal impacts of being a partner in a relationship with an individual with a gambling problem
- barriers to help-seeking for problem gambling, from the perspective of partners who live with an individual with a gambling problem

These interviews will be recorded and analysed by the researchers. The recordings will be kept in a secure location and will not be available to anyone outside the research team.

Commitments:

Each participant will be invited to participate in one face-to-face interview which will last for approximately one hour.

Benefits:

There will be no direct benefit for participants. The study will assist researchers to better understand the experiences and needs of famiies living with an individual who has a gambling problem and is not actively seeking help

What will happen to me at the end of the study?

Following you interview there is no further requirement for you to be involved. However if you wish to speak further about gambling related issues we can arrange for you to see one of our SGTS therapists. For your involvment in this study you will be offered an honorarium of $40.

Risks:

There are no perceived risks to clients as a result of this study.

Compensation:

If you suffer injury as a result of participation in this treatment and research programme, compensation might be paid without litigation, however, such compensation is not automatic and you may have to take legal action to determine whether you should be paid.

Confidentiality:

All records containing personal information will remain confidential and no information which could lead to your identification will be released, except as required by law.

Publication:

The findings of this study may be published in scientific journals at a later date. It is possible that the results may not be published for commercial, scientific or other reasons. There will be no reference in such reports to any individual participant in the SGTS treatment or research programme.

Withdrawal:

Participatants are free to withdraw from the study at any time.
Contact:

Please contact Professor Peter Harvey (08 84042541) if you have any questions about your involvement in the study.

Complaints:

The processes and procedures of this study have been reviewed by the Southern Adelaide Clinical Human Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant or should you wish to make a confidential complaint, you may contact the Executive Officer, SAC HREC at the Flinders Medical Centre (8204 6453) or email research.ethics@health.sa.gov.au.

CONSENT TO PARTICIPATION IN RESEARCH

I, ...
(first or given names) *(last name)*

give consent to my involvement in the research project

....
(short title)

I acknowledge the nature, purpose and contemplated effects of the research project, especially as far as they affect me, have been fully explained to my satisfaction by

....
(first or given name) *(last name)*

and my consent is given voluntarily.

I acknowledge that the detail(s) of the following has/have been explained to me, including indications of risks; any discomfort involved; anticipation of length of time; and the frequency with which they will be performed, eg

- electronic recording of interview

I have understood and am satisfied with the explanations that I have been given.
I have been provided with a written information sheet.
I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.
I declare that I am over the age of 18 years.
I acknowledge that I have been informed that should I receive an injury as a result of taking part in this study, I may need to start legal action to determine whether I should be paid.

Signature of Research Participant : .... Date: ....

I, ... have described to ....
the research project and nature and effects of procedure(s) involved. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature: .... Date: ....
Status in Proje

Appendix 11. Qualitative study 2 recruitment flier

Appendix 11. Recruitment flier for qualitative study 2.

Does your partner have a gambling problem?

The Statewide Gambling Therapy Service is seeking individuals living with a partner with a gambling problem who is not actively seeking or receiving help to participate in a study.

Information gained from a brief face-to-face interview about your experience living with a partner with a gambling problem will help the service to develop effective interventions for families of non-help-seeking problem gamblers.

Participants must be over 18 years of age and will receive a $40 gift card for their involvement in the study.

Interviews will be carried out the Statewide Gambling Therapy Service offices at Flinders Medical Centre, Salisbury or Port Adelaide.

Contact Ben Riley on 8204 6982 or email Ben.Riley@health.sa.gov.au

This study is approved by the Southern Adelaide Clinical Human Research Ethics Committee.

Government of South Australia

Flinders University

For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

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For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

For further information, please call Ben Riley on **8204 6982** or email **ben.riley@health.sa.gov.au**

Appendix 12. Qualitative study 2 interview questions

Interview questions: partners of non-help-seeking individuals with gambling problems

Semi structured questions

1. Tell me about you experience living with someone who has a gambling problem – how it has affected you and your relationship.

2. I'm interested in how you respond when your partner has gambled and when they haven't gambled.

3. I'm interested in whether you have approached your partner about their gambling and how this has gone.

Appendix 13. Characteristics of included studies: Role conflict and ambiguity, an umbrella review of literature reviews

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Agarwal, S., & Lenka, U. (2015).	India	Work/life balance female entrepreneurs	Family	Female entrepreneurs	Role conflict family and work – social role theory	Women take up entrepreneurship for flexibility
Almost, J. et al. (2016)	Canada	Interpersonal conflict	Healthcare	Healthcare workers	Overlapping roles – role ambiguity, unclear J&P	Six themes of stress, one was role ambiguity
Berghout, M. A. et al. (2017)	Netherlands	Medical leadership	Healthcare	Physicians in leadership roles	Role ambiguity when taking leadership role, role unclearly defined	Role ambiguity either positive (greater flexibility) or negative.
Blythe, J., & White, J. (2012)	UK	Role of MH nurse in physical health care in mental illness	Healthcare	MH nurse working in community or inpatient settings	Role ambiguity, unclear guidelines of role	Lack of guidelines and training for physical health led to role ambiguity
Brooks, S. K., & Greenberg, N. (2018)	UK	Non-deployment factors affecting wellbeing of military personnel	Other workplace	Military personnel across several countries	Role conflict and ambiguity. Conflict: work/family, conflicting job demands. Ambiguity: unclear expectations of role	Role conflict a source of stress. Suggestions for role clarification interventions and involving in decision making

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Carmona, E. et al. (2012)	Brazil	Experiences of mothers of hospitalised newborns	Healthcare	Mothers of hospitalised newborns	Role conflict	Multiple roles performed by mothers created conflict which heightened distress
Cheng, F. K. (2016)	Hong Kong	Use of mindfulness to reduce work place stress	Other workplace	Employees of large organisations	Role conflict: multiple and or competing work demands	Meditation reduced role conflict among health care professionals
Choo, C. E. et al.(2019)	Singapore	Work-life balance among college students	Other workplace	College students	Inter-role conflict	Inter-role conflict negatively affects college students' outcomes
Strech, D. et al. (2008)	Germany	Physician's experiences allocating resources to their patients	Healthcare	Physicians	Role conflict	Conflict between patient advocacy and containing costs
Dunbar, N., E. (2015)	USA	The influence of power in interpersonal relationships	Interpersonal relationships	Couples in close interpersonal relationships	Gender/sex role conflict	Females who display more power in their dyad
Duquette, A. et al. (1994)	Canada	Burnout among nurses	Healthcare	Nurses	Role ambiguity: unclearly defined role	Role ambiguity correlated positively with nurse burnout
Edwards et al. (1994)	UK	Stress/burnout Community mental health nurses	Halthcare	Community mental health nurses	Role conflict, role ambiguity. Role conflict: multiple roles inc. work/family. Ambiguity: unclear expectations	Increase of autonomy leads to role uncertainty

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Faraz, A. (2016)	USA	Nurse Practitioner to primary care	Healthcare	SR Novice NPs transitioning to primary care	Role ambiguity: unclear role expectations/responsibilities	3 themes emerged – role ambiguity was the theme most emphasised by NPs
Ferro, M. A., & Speechley, K. N. (2009	Canada	Depression symptoms among mothers of children with epilepsy	Caregiver	Mothers of children with epilepsy	Role ambiguity: multiple roles, boundary ambiguity	Role ambiguity positively associated with depression and worry
Flannery, L. et al. (2016)	Australia	Experiences of doctors and nurses in end of life decisions	Healthcare	Doctors and nurses in intensive care units	Role ambiguity: nurses greater ambiguity due to lack of clearly defined role	Greater collaborative decision making may mitigate ambiguity of clinical roles
Forth-Finegan, J. L. (1992)	USA	Influence of gender-roles on female alcoholics	Gender issues	Females with alcohol addiction	Role conflict	Gender-role conflict is both a determinant and consequence of female alcoholism
Jamie K. Fujioka et al. (2018)	Canada	Perspectives of health care providers in medical assisted dying	Healthcare	Health care providers: social workers, nurses, physicians, medical examiners, mental health providers, pharmacists.	Role ambiguity: unclearly defined roles	Role ambiguity most commonly reported by nurses. Lack of clarity around limits of their role. Not reported specifically by physicians.
Gerstner, C. & Day, D. (1997)	USA	Leader-member exchange theory	Other workplace	Leaders of organisations	Role conflict, role ambiguity: multiple demands, unclear expectations of role	Positive relationship between leader and follow negatively correlated with role conflict and ambiguity
Gibbons et al. (2014)	USA	Family experience of caregiving	Caregiver	Families caring for a family member	Role ambiguity during transition to being a carer	Role ambiguity was one of 4 themes during the transition/rite of passage period

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Giles, T. M., & Hall, K. L. (2014)	Australia	Nurse-family member experience admitting a family member for critical care	Caregiver	Nurse-family members	Role conflict: competing demands of multiple sometimes competing roles	Dual role conflict was deemed a burden, with the two roles inseparable. Created boundary issues.
Glover, D. E. et al. (2006)	USA	Perioperative nurse role delineation	Healthcare	Perioperative specialist nurses	Role ambiguity: unclearly defined expectations	Lack of clear role definition and expectations created ambiguity
Goss, E. (2017)	Ireland	Parents of children in long term care hospital	Caregiver	Parents	Role conflict and ambiguity: parents negotiated being expert about child's health, and being a caring parent	Conflict between being both a parent and expert of child's condition
Holdsworth et al. (2012)	Australia	Women's experience of problem gambling (PG)	Gender issues	Women problem gamblers	Role conflict: multiple roles which were incompatible	Conflict between caring for family and PG led women to seek help
Hooper, M. (2016)	Australia	Experience of graduate mental heal nurses first year of practise	Healthcare	Graduate mental health nurses	Role ambiguity: unclear of role expectations	Role ambiguity needs to be acknowledged and can be mitigated by supervision
Keim et al. (2014)	USA	Predictors of job insecurity	Other workplace	Employees of organisations	Role conflict and ambiguity: expectations of role, multiple roles and demands	Role conflict and ambiguity predicted perceptions of job insecurity
Kossek, E. & Ozeki, C. (1998).	USA	Work family conflict policies and job satisfaction	Other workplace	Employees of organisations	Role conflict: multiple competing roles	Negative relationship between work family conflict, and life satisfaction
Lambert, D. & Lambert, V. (1988)	USA	Impact of role conflict on nurses	Healthcare	Nurses in nurse faculties	Role conflict: multiple roles competing,teaching and clinical practice	Role conflict within nurse faculty programs

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Lazzari et al. (2014)	Brazil	Knowledge of teaching among nurse faculty	Healthcare	Nurse higher education teachers	Role conflict: teaching and clinical practice roles	Role conflict between being a teacher and clinician
Lim, J. et al. (2010)	Australia	Stress and coping among nurses	Healthcare	Australian nurses	Role ambiguity: unclearly defined roles, unclear expectations of role	Role ambiguity reported among range of stressors and led to job dissatisfaction
Lines, L. E. et al. (2015)	Australia	Nurse-parent experiences	Caregiver	Nurses	Role conflict: negotiating role of parent and clinical nurse	Nurse-parents found if challenging separating their dual roles, both positive and negative experience
Loscosso, K & Roschelle, A. (1991)	USA	Influences on quality of work and non-work life	Other workplace	Employees of organisations	Role conflict and ambiguity: expectations of the role, multiple roles/demands	Role conflict and ambiguity negatively correlated to job satisfaction and involvement
Lu, H. et al. (2012)	China	Job satisfaction among nurses	Healthcare	Nurses	Role conflict and ambiguity	Role conflict and ambiguity greatest sources of job stress among nurses
Lu, H. et al. (2019)	China	Job satisfaction among nurses	Healthcare	Nurses	Role conflict	Work – family conflict related to job dissatisfaction
Lundy, C. (1987)	Canada	Sex-role conflict among female alcoholics	Gender issues	Females with alcohol disorder	Role conflict	Greater role conflict related to greater drinking
Mackie, A. & Bates, G. (2019)	Australia	RHD environment and PhD candidates' mental health	Other workplace	Education PhD candidates	Role conflict: multiple roles	Work-family conflict a source of student stress

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Maudgalya, T. et al. (2006)	USA	Burnout among information technology professionals	Other workplace	Information technology professionals	Role conflict and ambiguity: unclearly defined expectations, multiple roles/competing priorities re job tasks	Role conflict and ambiguity positively related to burnout
Michel, J. et al. (2011)	USA	Work-family conflict	Other workplace	Employees	Role conflict and ambiguity	Role conflict a greater predictor of stress than role ambiguity
Moore, T. & Stuart, G. (2005)	USA	Masculinity and partner violence	Gender issues	Males in intimate relationships	Role conflict: gender role violation by men	Role gender conflict related to male aggression towards partner
Mulvhill, C. et al. (2010)	Australia	Role of specialist palliative care nurses	Healthcare	Specialist palliative care nurses and team	Role ambiguity around role of palliative care nurse in end of life care	Need for greater clarification of the role of specialist palliative care nurses
Nouri, H & Parker, R. (2018)	USA	Turnover in public accounting firms	Other workplace	Employees of public accounting firms	Role conflict and ambiguity. Role ambiguity: unclear role expectations. Conflict: work/family roles	Mentoring may mitigate ambiguity, and flexible working hours for work-family conflict
Olsson, M., & Martiny, S. (2018).	Norway	Influence of counter-stereotypical role models on females' career choices	Gender issues	Females	Role conflict: marriage-career-conflict: role models?	Exposure to counter-stereotypical role models can influence stereotypes
Omansky, G. (2010)	USA	Experiences of nurse mentors/preceptors	Healthcare	Nurse preceptors	Role conflict and ambiguity. Role ambiguity: unclear expectations of the role. Conflict: multiple roles, demands of teaching/mentoring and patient care	Role conflict and ambiguity can be reduced by greater role clarification and acknowledgment of role

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Ortqvist, D. & Wincent, W. (2006)	Sweden	Meta-analysis of Role Stress	Other workplaces	Individuals across range of contexts	Role conflict and ambiguity: multiple roles competing, and competing expectations across a single role	Role conflict and ambiguity detrimental to individuals
Podsakoff, P. et al. (2006)	USA	Leader reward punishment behaviour	Other workplace	Employees and employers in organisations	Role ambiguity	Relationship between leader reward punishment mediated by role ambiguity
Ramazanu, S. et al. (2020)	Hong Kong	Couples coping post stroke of spouse	Caregiver	Couples post stoke of spouse	Role conflict. Multiple roles: carer, partner	Male patients conflicted about role change to receiver of care
Riahi, S. et al. (2016)	Canada	Decision making factors when restraining patients	Healthcare	Mental health nurses	Role conflict: incompatible roles	Role conflict related to balancing safety and ethics
Sabyani, H. et al. (2017)	USA	Nurses experience having a family member hospitalised	Healthcare	Nurses	Role conflict: dual roles being family member and nurse in conflict	Role conflict moving between being a relative and being a healthcare worker +
Saks, A. et al. (2007)	Canada	New employee adjustment	Other workplace	New employees of organisations	Role conflict and ambiguity: multiple roles, unclear expectations	Social adjustment negatively related to role conflict and ambiguity
Smith, A. (2011)	USA	Nurses transition from bedside care to case management	Healthcare	Nurse case managers	Role conflict and ambiguity concerning patient care vs patient rights	Role conflict and ambiguity negatively impacts job satisfaction and performance
Tay, L. et al. (2018)	Singapore	Cancer patient experience of nurse counselling	Healthcare	Cancer patients receiving counselling by nurses	Role ambiguity: nurses' role in providing counselling to patients	Role ambiguity negatively impacted on nurse patient relationship

Author/s	Country	Study focus	Setting	Sample/population	Type of conflict	Findings
Twenge, J. et al. (2003)	USA	Marital satisfaction and parenthood	Interpersonal relationship	Married parents	Role conflict: re-organisation of roles following addition of children	A re-organisation of social roles can lead to role conflict among parents
Van den Brande, W. et al. (2015)	Belgium	Workplace bullying	Other workplace	Employees of organisations	Role conflict and ambiguity	Role conflict and ambiguity related to being victim of bullying
Wirtz, J. & Jerger, C. (2016)	Singapore	Managing service industry employees	Other workplace	Employees and employers in the service industry	Role conflict: customer satisfaction vs sales	Role conflict was related to poor job performance and employee stress
Worthington, E. & Buston, B. (1986)	USA	Couples' transition to parenthood	Interpersonal relationship	Married couples with children	Role conflict: role strain theory, multiple roles leads to role conflict	Role conflict common among new parents and women affected more
Wynne-Jones, G. et al. (2010)	UK	GP's perspectives about sickness certifications	Healthcare	General practitioners	Role conflict: providing sickness certificates, patient interests vs doctors' interest	Conflict between needs of Dr patient, and Dr and other stakeholders

Appendix 15. Systematic review: published paper

Appendix 15. Systematic review; accepted manuscript

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Gambling-related harm for concerned significant others: A systematic review and meta-synthesis of empirical studies

Abstract

The availability of legalized gambling products has increased over the past three decades. Though the negative personal consequences of problem gambling (PG) are well documented, a comprehensive picture of gambling-related harm from the perspective of concerned significant others (CSOs) is lacking. The aim of this systematic review was firstly, to describe the nature of existing peer-reviewed published studies from inception through to July 2018 that have directly engaged CSOs concerning gambling-related harm. Secondly, to synthesize this literature and describe the impacts of PG on CSOs; how CSOs respond to gambling-related harm; identify gaps in the literature, and provide specific directions for future research. A systematic search strategy identified 53 studies. Following the extraction of data, a meta-synthesis was conducted on the 26 quantitative, 21 qualitative and 6 mixed-methods studies. Partners are especially impacted, suffering both mental and physical health problems. Children are also particularly affected, and appear to suffer silently due to their reluctance to disclose their parental PG worries. Problem gambling treatment and counselling services should take into account the pervasiveness of the impacts of PG and be equipped to respond appropriately

to the needs of CSOs. Future research should focus on male CSOs, and CSOs associated with non-help-seeking problem gamblers.

Keywords: problem gambling; concerned significant others; families; addiction; systematic review

Introduction

Problem gambling rates worldwide range between 0.12–5.8% (past 12 months) and 0.7–6.5% (lifetime), the variability being due in part to different methodological procedures, instruments, cut-offs, and time frames (Calado & Griffiths, 2016). In general, the evidence suggests that problem gambling rates began increasing in North America and Australia in the late 1980s to early 1990s, coinciding with the expansion of legalized gambling opportunities, particularly casinos and electronic gambling machines (Williams, Volberg & Stephens, 2012). Between 1980 and 2006 Australia experienced a doubling in the amount of disposable household income spent on gambling, the majority of this increase occurring in the mid-nineties following the introduction of electronic gaming machines into hotels outside of major casinos. Presently Australia has the largest gambling expen- diture per capita in the world (Armstrong & Carroll, 2017). Despite a steady increase in the availability of gambling in most jurisdictions over the past three decades, worldwide there has been a general downward trend in problem gambling rates since around 2000, with rates now similar to where they were in the late 1980s (Williams et al., 2012). That being said, afflicted individuals contribute significantly and disproportionately to gam- bling expenditure, with a reported 40% of all losses from electronic gaming machines con- tributed by problem gamblers (Productivity Commission, 2010).

Problem gambling (PG) is associated with significantly harmful personal and social impacts such as occupational loss, family breakdown and suicide (Productivity Com- mission, 2010). In addition, for every problem gambler 4–10 others such as partners and children are also adversely affected and experience the emotional, social and financial stress caused by PG (Goodwin, Browne, Rockloff, & Rose, 2017; Productivity Commission, 2010). Despite this only a small number of problem gamblers seek pro- fessional help. Recognizing the need for help and making the decision to seek treatment for gambling problems, are affected by a number of factors such as embarrassment, denial and shame (Evans & Delfabbro, 2005). Volberg (1999) found just 3 percent of problem gamblers sought help in Oregon USA. The Productivity Commission (2010) estimated the figure at around 15 percent. Furthermore, help seeking is often a last resort after experiencing significant negative consequences such as legal proceedings, family break up, job loss or physical or psychological breakdown (Evans & Delfabbro, 2005; Productivity Commission, 2010). Whilst few seek professional treatment, problem gamblers often turn to family members or friends for informal help (Hing, Tiyce, Holdsworth, & Nuske, 2013) highlighting the need to better understand this private world.

The adverse impact PG can have on individuals afflicted is well documented (Dowling et al., 2015; Lorains, Cowlishaw, & Thomas, 2011; Neal, Delfabbro, & O'Neil, 2005). Though there is growing interest in examining the negative impacts of PG more broadly (Langham et al., 2016; Shannon, Anjoul, & Blaszczynski, 2017), the bulk of the literature regarding PG has focused on individuals with the addiction, with much less attention given to the impact it has on their families, including partners, children, parents, and other relatives.

Given the number of concerned significant others (CSOs) affected by an individual's gambling problem (Productivity Commission, 2010), this is surprising. The impact that substance related addictive disorders such as excessive alcohol use, has on family life, is well documented (Hutchinson, Mattick, Braunstein, Maloney, & Wilson, 2014). In con- trast, the impact of PG on families has been given much less attention. Whilst there has been a growing interest in this topic over the past several years, there remains a lack of systematic reviews on gambling-related harm for concerned significant others. A systema- tic review by Kourgiantakis, Saint-Jacques, and Tremblay (2013) examined studies related to PG and families. The authors examined published and unpublished empirical studies written or published between 1998 and 2013. Studies that collected data from both CSOs and or gamblers were included. The purpose of their review was to examine the impact of PG on families and the involvement of families in PG treatment. Results of the review, based on 30 empirical studies, present the impact of gambling-related harm on partners and children, along with a focus of families' involvement in treatment. The main findings included a lack of understanding and awareness among partners as to the extent of the gambling problem and the negative impacts on the spousal relationship, and relationships with extended family. Family involvement with treatment appeared to have a positive effect on outcome.

Though a number of studies involving problem gamblers have examined the impact on CSOs and family functioning from the perspective of the gambler, there is some evidence of a divergence in perspectives between problem gamblers and their partners. Problem gamblers perceive their family functioning and the impact of PG on their family more positively than their partners (Cunha & Relvas, 2015; Cunha, Sotero, & Relvas, 2015; Goodwin et al., 2017; Lorenz & Yaffee, 1988), and perceive neglect of their responsibilities as less problematic than perceived by their partners (Li, Browne, Rawat, Langham & Rockloff, 2017). A recent

study investigating gambling-related experienced by affected others, suggested that gamblers seemed unaware of the broader impacts of their gambling (Landon, Grayson, & Roberts, 2018). To properly understand the impact of PG on CSOs, it is prudent therefore, to examine data collected from the CSOs themselves. For this reason the current systematic review is focused on published empirical studies that col- lected data directly from CSOs. Though there is some overlap with the Kourgiantakis et al. (2013) review, the disticntion with the present review is a focus on gambling- related harm as reported by concerned significant others.

The spectrum of gambling participation

Gambling is defined as 'to play a game for money or property' and to 'bet on an uncertain outcome' (Merriam-Webster, 2017a). It is a particularly common behaviour in most parts of the world with rates of gambling participation during the previous 12 months ranging between 25% (Czech Republic) to 82% (USA). Problem gambling has been defined as 'difficulties in limiting money and/or time spent on gambling which leads to adverse con- sequences for the gambler, others, or for the community' (Neal et al., 2005, p. 3). Research- ers have found it useful to distinguish between sub-clinical and clinical levels of PG to separate individuals who have severe gambling problems from those with moderate pro- blems (Shaffer, Hall, & Vander Bilt, 1999). The Diagnostic and Statistical Manual for Mental Health Disorders, Fifth Edition describes Gambling Disorder as 'persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more)' symptoms as described by a checklist over a 12-month period (Americal Psychiatric Association, 2013, p. 587). Other researchers are of the view that gambling behaviour should be con- sidered as a continuous variable, ranging from social or recreational gambling where there are no adverse impacts for the

gambler or others arising from the gambling behaviour, through to problem gambling which arises when the gambling behaviour impacts adversely on the gambler and or others (Neal et al., 2005). Individuals can experience pro- blems at many points along this continuum (Tse, Hong, Wang, & Cunningham-Williams, 2012).

Aims and objectives

The current study is focused on and aims to systematically review published peer reviewed empirical studies from inception to July 2018, on the impact of PG on CSOs, and to sum-marize the evidence on the impact on individual family members, friends, family life and family relationships. In addition, it aims to examine the efforts CSOs make in minimizing the harm caused by PG, including their attempts to encourage the gambler to seek help. Many studies on PG and families have used clinical populations. Given only a small number of problem gamblers seek formal treatment (Productivity Commission, 2010; Volberg, 1999), this presents a sampling bias. In describing and synthesizing the evidence in this review, a distinction is made between clinical and community populations.

The term significant other, has been defined as ‘a person who is important to one’s well-being; especially: a spouse or one in a similar relationship’ (Merriam-Webster.com, 2017b). In the PG literature, the term concerned significant other has been commonly used to refer to any individual who has a relationship with a problem gambler. This com- prises family members including partners/spouses, parents, children and extended family, as well as friends (for example, Dowling, Rodda, Lubman, & Jackson, 2014; Makarchuk, Hodgins, & Peden, 2002; Salonen, Castrén, Alho, & Lahti, 2014; Svensson, Romild, & Shepherdson, 2013). For this review, the term CSO, refers to any individual who has ident- ified that they have a friend or family member with a gambling problem. For example, a Finnish population study

identified CSOs by asking if any of the following; father, mother, sister/brother, grandparent, spouse, own child/children or close friend, had a gambling problem (Salonen et al., 2014).

Specifically, the aims of this current review are firstly, to describe the nature of existing peer-reviewed published studies that have directly engaged CSOs concerning gambling- related harm, providing a distinction between clinical and non-clinical populations. Sec- ondly, to improve our understanding of the degree and nature of: the impacts of PG on CSOs; how CSOs respond to gambling-related harm; identify gaps in the literature, and provide specific directions for future research.

Methods of the review

The Preferred Reporting Items for Systematic reviews and Meta-Analyses Protocols (PRISMA-P) (Moher et al., 2015) were followed for the current review.

Search strategy and scope and inclusion criteria for studies in this systematic review

All study designs (e.g. cross-sectional, randomized control trial, qualitative interviews, population studies, observational studies) that collected data from CSOs directly were included in the review. The following databases were used for the systematic search: PubMed, Scopus and PsychInfo. In addition, reference lists of all included studies were searched manually. The structured search strategy was implemented on the 27 June 2018 with the assistance of an academic librarian holding postgraduate qualification in information management. Given the limited literature in this area, the search included all studies from inception through to July 2018. The search terms used for each database are presented in Figure 1. Only empirical studies published in peer reviewed journals in English were

included. Studies were included if they contained data concerning the impact on, or experience of PG on the gambler's family member/s. For the current review, a broad definition of PG was used. The individual with the gambling problem was not required to be formally diagnosed with a Gambling Disorder. It was sufficient, for example, that the affected family member reported that their family member (whether it be partner, spouse, child or parent) had a gambling problem. Studies that did not collect data directly from the gamblers' CSOs were excluded. For example, a number of studies have examined problem gamblers' perspectives on their marital status, family and relationship functioning (Black, Shaw, McCormick, & Alien, 2012; Ciar- rocchi & Hohmann, 1989; Ciarrocchi & Reinert, 1993). Though such studies may provide some insight into the experiences of CSOs of problem gamblers from the perspective of the gambler, they were not included in this review. Thus, the aim of this review is to produce a summary of the current state of knowledge of gambling-related harm from the perspective of CSOs.

Assessment of methodological quality

All papers identified through the search process were assessed independently by two reviewers for methodological quality prior to inclusion in the review. Assessing the quality of published studies for inclusion in systematic reviews can be achieved by using either a components checklist, or a scale that provides an aggregate score. There is a variety of instruments available designed to assess the quality of empirical studies. Such instruments are not homogenous, with some including items more related to the quality of reporting, and others with more emphasis on the methodological quality of the study (Jüni, Witschi, Bloch, & Egger, 1999). Use of a scale to produce an overall quality score is not well supported by empirical research, and the use of such scales is advised against by the Cochrane

Collaboration (Higgins & Green, 2006; Lundh & Gøtzsche, 2008). As such, the use of scoring to determine the quality of studies, was not used for this review. Quantitative papers were assessed using the McMaster University

Critical Review Form, Quantitative Studies Version (Law et al., 1998). Items included purpose and need for study, design, sample size, outcomes, details of the intervention, results, conclusions and implications. Qualitative papers were assessed using the McMas- ter University Critical Review Form, Qualitative Studies Version 2.0 (Letts et al., 2007). Items included purpose, need for study, qualitative design, theoretical or philosophical perspective, issues related to sampling and participant selection, methods for data collec- tion, and the context of the study. Mixed study papers were assessed using the Mixed Methods Appraisal Tool Version 2011 (MMAT; (Pluye et al., 2011). Items included objec- tives of study, sources of data, sampling strategies, relevance of a mixed methods design and integration of qualitative and quantitative data. All papers were assessed indepen- dently by the two reviewers using the aforementioned instruments. The reviewers then met to compare and discuss the assessments until consensus was reached. There were no disagreements requiring consultation with a third reviewer. Methodological assess- ments were performed to report on the quality of studies and not used as portal for inclusion of studies into the review.

The findings of all included studies were synthesized following the Economic and Social Research Council's guidelines on narrative synthesis (Popay et al., 2006). A preliminary synthesis was conducted which firstly involved producing a textual description paragraph of each study. These were then uploaded into NVivo 11 qualitative data software tool to help organize the findings. An initial set of categories concerning the main findings across studies

was then developed. These categories were discussed by the review team until con- sensus was reached. Following this, the preliminary categories were then subjected to a meta-synthesis and re-grouped on the basis of similarity and meaning. These themes and categories were then used to explore the patterns and relationships within and between studies to produce a comprehensive set of findings. Finally, the robustness of the synthesis was examined.

Results

Application of the search terms identified 4181 articles. These were then combined into an Endnote library for screening. Following removal of duplicates, the inclusion criteria were applied to 3836 articles. Following the exclusion of 3613 articles, abstracts and/or full articles were examined for the remaining 223 articles and 171 were excluded. Among the remaining 52 articles, one study was found to have been reported twice in separate journals (Lorenz & Yaffee, 1988, 1989) and was therefore counted as one article. The refer- ence lists of the remaining 51 manuscripts were then searched by hand which located a further 2 studies. This resulted in a final total of 53 studies for the review. The results of this process are presented in Figure 2. Countries from which the greatest number of studies was conducted were Australia (16 studies; 30%), the USA (9 studies; 17%) and Canada (7 studies; 13%). Twenty one (40%) of the studies involved quantitative, 26 (49%) qualitative and 6 (11%) mixed methods methodology. Eighteen studies (34%) com- prised CSO data drawn from clinical populations, (that is, where the gambler was receiv- ing help or had completed a course of counselling and was in recovery). A further 34 studies (64%) did not report the help-seeking status of the gambler. One study (Patford, 2009) involved a deliberate effort not to rely solely

on a clinical population, though did not report the help-seeking status of the gamblers. Characteristics of the studies are presented in appendix 1.

Methodological quality

Overall, the included studies possessed a high level of methodological rigour. The greatest issue among quantitative studies was the failure to report study dropouts. In addition, around a fifth of quantitative studies did not adequately describe the study sample. Among qualitative studies, around half did not identify a theoretical perspective, and although most studies detailed ethical clearance from a formal ethics committee, the vast majority did not report obtaining informed consent from participants. One third did not describe the purposeful selection process used in selecting study participants, and three fifths of qualitative studies did not identify potential influences, biases and assumptions of the researcher. Overall, a high level of rigour was observed in the reporting of qualitative data analyses including the provision of a decision trail. Likewise for the mixed-methods studies, the majority did not address the researchers' potential influence. Furthermore, the majority of mixed-methods studies did not discuss the chal- lenges and limitations of integrating qualitative and quantitative data. Some of these observations may be a product of the timespan of the studies, in that reporting require- ments thirty years ago were somewhat different to today. Results of the methodological assessments are presented in appendices 2–4.

Synthesized findings

The preliminary synthesis (Popay et al., 2006) resulted in 31 preliminary themes and 18 sub-themes which were collapsed into four themes and 11 sub-themes. Themes and sub-themes

for the meta-synthesis are presented in Table 1. These relate to impacts on CSOs' health, impacts on relationships with family members, and CSOs help-seeking behaviour.

Impact on CSO's mental health (partners)

A significantly higher prevalence of mood disorders has been reported among partners of PGs (Dannon, Lowengrub, Aizer, & Kotler, 2006; Goodwin et al., 2017; Rychtarik & McGillicuddy, 2006; Svensson et al., 2013; Wenzel, Øren, & Bakken, 2008) with psycho- logical symptoms comparable to psychiatric inpatients (Makarchuk et al., 2002). Emotional distress was frequently reported (Dowling, Smith, & Thomas, 2009; Chan, Dowling, Jackson, & Shek, 2016) and such experiences (stress, depression and anxiety) directly attributed to the partner's gambling problem (Holdsworth, Nuske, Tiyce, & Hing, 2013; Lorenz & Shuttlesworth, 1983). In some cases the gambling increased follow- ing deterioration in the partner's mental health, due to the gambler fearing they were losing their support (Boyd & Bolen, 1970), creating a vicious cycle. Personal distress was significantly and positively related to relationship distress (Hodgins, Shead, & Makarchuk, 2007). Anger and depression were found to be the most commonly reported emotional problems reported by CSOs (Lorenz & Yaffee, 1989). Two studies however, reported CSOs did not express greater signs of negative affectivity than non-CSO controls (Dowling et al., 2009; Mazzoleni, Gorenstein, Fuentes, & Tavares, 2009). Around 13 percent of CSOs had experienced feeling suicidal (Lorenz & Yaffee, 1989) or attempted suicide with such attempts occurring following CSOs threatening separation or divorce actions (Lorenz & Shuttlesworth, 1983). Emotional distress was higher among CSOs who were living with as opposed to not living with the gambler (Makarchuk et al., 2002; Orford, Cousins, Smith, & Bowden-Jones, 2017) and wives experienced greater dis- tress than other family members (Orford et al., 2017).

CSOs' risky alcohol and or other drug use

Large population studies found that CSOs (including partners, friends or other relatives) reported higher rates of smoking and risky alcohol use than for the general population (Salonen, Alho, & Castren, 2015; Svensson et al., 2013). Partners reported engaging in dys-functional behaviours such as drinking, smoking, over eating and impulsive spending to help cope with the problem (Lorenz & Shuttlesworth, 1983). Gender differences were reported with male CSOs more likely to engage in risky drinking and females more likely to be daily smokers (Salonen et al., 2014).

Impact on CSO's physical health (partners)

CSOs reported impaired physical health which they attributed directly to the gambling problem (Wenzel et al., 2008; Chan et al., 2016; Salonen, Alho, & Castren, 2016). Female partners reported experiencing physical ailments during the worst of the gambling episodes. These included as chronic or severe headaches, irritable bowel issues (Lorenz & Yaffee, 1988), stomach problems, feeling faint or dizzy, breathing irregularities, backaches, high blood pressure (Lorenz & Yaffee, 1989) and poor sleep (Landon et al., 2018; Li et al., 2017). Male partners also reported experiencing physical issues such as hypertension and feeling exhausted which affected their work (Patford, 2007a). A significant association was found between CSOs' physical illnesses and psychological difficulties, supporting the hypothesis that partners of CSOs experience physical disorders due to living under con- ditions of stress brought about by PG (Lorenz & Yaffee, 1988). A large population study conducted in Finland reported being a CSO was significantly associated with poor health and wellbeing regardless of gender (Salonen et al., 2014).

Impact on the marital/couple dyad

Unsurprisingly, PG had a substantial negative impact on couples' relationships (e.g. Landon et al., 2018; Harrison & Donnelly, 1987). Gamblers, however, rated this impact of their gambling on their partner lower than the rating the partners gave, suggesting they tended to underestimate the negative effect of their gambling on their partners (Ferland et al., 2008). In some cases, interpersonal conflict was caused by the attempts the couples engaged to manage the problem, such as CSOs taking control of the finances, and constant monitoring for gambling behaviour. A recent study examining gambling-related harm on affected others, found neglect of responsibilities was the most severe relationship harm (Li et al., 2017). CSOs often described their gambling part- ners as 'childlike' (Dickson-Swift, James, & Kippen, 2005). Interpersonal conflict was fre- quently reported among both male and female CSOs (Crisp, Thomas, Jackson, & Thomason, 2001) with threats of separation or divorce common (Lorenz & Shuttlesworth, 1983). Deciding whether to leave or stay in the relationship was a significant issue for some female partners who described that the consideration of leaving was accompanied by sub- stantial fears about what the future held (Patford, 2009; Borch, 2012).

Hypervigilance

A common experience reported by CSOs was a chronic enhanced state of anxiety attrib- uted to fear that the partner might be gambling or about to gamble (Heineman, 1987; Holdsworth et al., 2013; Krishnan & Orford, 2002). This led to CSOs continuously seeking evidence of gambling, such as checking bank statements or searching clothing for betting slips (Krishnan & Orford, 2002; Patford, 2009). Female CSOs expressed difficulty in detecting gambling behaviour, commenting that it was not as easy as detecting drinking (Heineman, 1987).

Therefore, they continued to worry that the amount of debt was greater than what they were led to believe: 'the wives of the gamblers had no reliable barometer for detection; thus, their anxiety appeared greater' (Heineman, 1987, p. 34). Such monitoring behaviours were reported to have had a negative impact on the relation- ship in that they made the gambler defensive and resentful (Patford, 2007a). Feelings of resentment were likewise experienced by CSOs for feeling they were going without even basic necessities, due to lack of finances (Dickson-Swift et al., 2005).

Hypervigilance was also related to CSOs receiving and fearing contact from creditors (Mathews & Volberg, 2013), fearing the gambler may lose his or her job, and worry about the gambler's depression, mood swings, physical health and unhealthy appearance (Krishnan & Orford, 2002). A population study reported all self-identified CSOs had indi- cated they had provided the gambler with money they believed would be used to either gamble or pay gambling-related debts (Svensson et al., 2013). Such enabling behaviour was explained by some CSOs by their fear that the gambler would resort to criminal activity to obtain money (Krishnan & Orford, 2002). A number of CSOs reported being frightened to answer the door for fear it might be the police (Dickson-Swift et al., 2005). Partners described feeling terrified by the uncertainty that had entered their lives (Holdsworth et al., 2013).

Conflict including familial violence

Familial violence was not an uncommon experience among CSOs. Almost 80 percent of women attending a forensic medical clinic in Turkey reported their male partner had a gambling problem, and more than a third attributed the reason for the assault, which prompted their attendance at the clinic, to the gambling problem (Balici & Ayranci, 2005).

Having a partner with a gambling problem increased the odds of experiencing familial violence among women attending an emergency department in the United States (Muelleman, DenOtter, Wadman, Tran, & Anderson, 2002). Female CSOs in a recent New Zealand study described verbal and physical abuse following arguments about their partners' gambling (Landon et al., 2018). A population study in Finland found that CSOs were significantly more likely to report being subjected to domestic vio- lence during the previous 12 months compared to non-CSOs (Svensson et al., 2013). A large study across Australia and Hong Kong reported more than half of CSOs indicated some form of familial violence during the previous 12 months, with females more likely to report victimization than males (Suomi et al., 2013). A New Zealand study, however, found that the relationship between familial violence and PG became insignificant after controlling for alcohol use (Schluter, Abbott, & Bellringer, 2008).

Financial distress

Most CSOs experienced financial difficulties (Lorenz & Shuttlesworth, 1983; Landon et al., 2018) with more female CSOs indicating financial stress than males (Crisp et al., 2001). Gambling related debts appeared to be the most common source of financial stress (Holds-worth et al., 2013; Krishnan & Orford, 2002; Mathews & Volberg, 2013; Valentine & Hughes, 2010; Lesieur, 1979) resulting in some CSOs returning to work or working extra hours to help with the repayments (Holdsworth et al., 2013; Krishnan & Orford, 2002; Mathews & Volberg, 2013). In some cases, the financial problems were such that CSOs resorted to borrowing money to support basic needs (Lorenz & Shuttlesworth, 1983) or families having to sell their home (Mathews & Volberg, 2013). Financial harms continued to impact families even when the gambler ceased gambling (Langham et al., 2016).

CSOs other than partners

Children. Children of PG parents were more likely to exhibit PG behaviours themselves (Vachon, Vitaro, Wanner, & Tremblay, 2014; Jacobs et al., 1989) and reported higher levels of alcohol and tobacco use and a greater preference for stimulant drugs than chil- dren of non-PG parents (Jacobs et al., 1989). Some adult children however, reported that being exposed to heavy gambling as a child, made them less likely to gamble (Landon et al., 2018). Children of PG parents reported almost twice the incidence of par- ental separation or death of a parent, twice the rate of use of prescription antidepressants and twice the amount of suicide attempts than children of non-PG parents (Jacobs et al., 1989). Difficulties at school were also reported among children of PG parents, such as behavioural or adjustment problems and running away from school or home (Lorenz & Shuttlesworth, 1983). A common form of neglect involved children being left unattended while the parent gambled (Landon et al., 2018; Li et al., 2017).

Children with a PG parent that had a co-morbid alcohol, drug or over-eating problem, reported greater problems than children with a parent a gambling problem only (Leiseur & Rothschild, 1989). Where the PG parent had acknowledged their problem and sought help, children scored better overall on psychological measures than families of non- help-seeking PGs (Leiseur & Rothschild, 1989). Gamblers neglected spending time with their family due to gambling (Langham et al., 2016). Partners of problem gamblers reported they did not feel the gambler spent enough time with their children (Lorenz & Yaffee, 1988). Children reported they could sense the tension in the family home (Patford, 2009; Darbyshire, Oster, & Carrig, 2001). Concern for the aversive manner the gambler treated their grandchildren was reported by adult children (Landon et al., 2018). Older children also indicated they were less

affected as they were financially independent (Patford, 2009), though adult children indicated they distanced themselves from their gambling parents due to fear that if they showed warmth they would be harassed for money (Mathews & Volberg, 2013). Adult children described how taking control of their parents' financial affairs had led to them perceiving themselves as their parents' caregiver (Langham et al., 2016; Patford, 2007b) while younger children were reported to take on household chores and stay home from school as a result of their parents' gambling (Langham et al., 2016).

Such distancing for fear of being harassed for money was reported also by more extended family members (Mathews & Volberg, 2013). In one study, 79 percent of children complained about the impact of PG on the family finances whereas only 36 percent of the gambling parents reported their gambling had a negative financial effect on their children (Wurtzburg & Tan, 2011). Problem gamblers therefore, tended to under- estimate the negative impact that their gambling had on both their partners (Ferland et al., 2008) and their children (Wurtzburg & Tan, 2011). Some children indicated being phys- ically abused by their gambling parent (Ferland et al., 2008) or grandparent (Landon et al. 2018). Children found it difficult to discuss difficulties associated with having a PG parent, with a third of children reporting they had never spoken about it with anyone outside the family home (Wurtzburg & Tan, 2011). Furthermore, parents were unaware of the difficulties their children experienced in discussing the negative effects of parental PG. One reason for children's reluctance, was that they wanted to be perceived as normal (Wurtzburg & Tan, 2011).

Parents. Only one study focused on the effects of adult children's gambling on parents and parents-in-law (Patford, 2007c). Patford's study (2007c) revealed such parents experi- enced diminished enjoyment in life, and increased physical and emotional stress along with financial problems. The gambling also placed pressure on the parents' relationship with their partners as they negotiated the best way to manage the situation. A recent quali- tative study by Landon et al. (2018) described conflict between a parent and their adult PG child concerning the gambler's ill treatment of their own children. The breakdown of relationship between adult gamblers and their parents impacting on grandchildren was also reported by Langham et al. (2016).

CSOs seeking help for themselves Given the enormous impacts of PG on CSOs, it is not surprising that many seek help for them- selves. Three decades ago Heineman (1987) made the comment that treatment for wives of alcoholics had been available for over three decades but treatment for wives of pathological gamblers was almost non-existent. The majority of CSOs pursued help for themselves firstly, through self-management strategies such as talking to the gambler about how the problem was affecting them, and organizing direct debit arrangements for household bills (Hing et al., 2013). In addition to self-coping, CSOs sought help from a range of sources including doctors, solicitors, bank employees and clergymen (Krishnan & Orford, 2002; Lorenz & Shuttlesworth, 1983) as well as family members and friends (Hing et al., 2013; Patford, 2009) and specialist gambling help services (Patford, 2009; Goh, Ng, & Yeoh, 2016). When approaching relatives or friends, CSOs were careful about how much and what they disclosed, fearing they might lose friends (Patford, 2009; Kourgiantakis, Saint- Jacques, & Tremblay, 2017). Though many CSOs sought help, others described a reluctance to do so unless motivated by their children (Landon et al., 2018).

Attempts by CSOs to encourage the gambler to seek help

CSOs have high awareness of gambling problems in the family and therefore offer a potentially useful pathway to help motivate problem gamblers to seek help (Wenzel et al., 2008; Kourgiantakis et al., 2017). Many CSOs had made attempts to encourage the gambler to seek help (Hing et al., 2013; Patford, 2007a, 2007c, 2009) employing a variety of strategies to encourage help-seeking and reduce their gambling. In some instances family members 'forced' the gambler to attend Gamblers Anonymous (Krishnan & Orford, 2002). Attempts to challenge the gamblers' erroneous gambling related beliefs was reported by some CSOs (Patford, 2007a, 2009). Other strategies included changing passwords for accounts, planning incompatible activities such as family outings (Valentine & Hughes, 2010), closing joint bank accounts (Patford, 2007a) and encouraging the gambler to talk to others about the problem (Krishnan & Orford, 2002).

Discussion

This review aimed firstly, to describe the nature of existing peer-reviewed published studies from inception through to July 2018 which directly engaged CSOs concerning gambling-related harm. Secondly, to synthesize this literature and describe the impacts of PG on CSOs; how CSOs respond to gambling-related harm, including their attempts to encourage the gambler to seek help; identify gaps in the literature, and provide specific directions for future research. The studies were published between 1979 and 2016. During the search and inclusion process, 47 studies were found that addressed the study's aims. Analysis of the 47 studies resulted in four meta-synthesised findings. These meta-syntheses address the impact of PG on partners' health, the spousal relation- ship, impact on CSOs other than partners, and the help-seeking behaviours of CSO's. The first synthesized finding concerned the impact of

PG on partners' mental and physical health. Partners experienced significant emotional distress such as depression, anxiety, anger and suicidal ideation, and elevated rates of risky alcohol use and smoking. Partners also reported impaired physical health such as headaches, backaches and hypertension. The second synthesized finding concerned the impact of PG on the spousal relationship. Substantial negative impacts were reported such as interpersonal conflict. Divorce and separation were common, as were high levels of domestic violence. Chronic hypervigilance was a common experience by partners, as they perpetually searched for evidence of gam- bling behaviour. The third synthesized finding related to the impact of PG on children, parents and extended family. Children displayed higher levels of risky behaviours and mental health concerns including suicide attempts, and reported high incidents of parental seperation. They were reluctant to disclose their emotional problems to their PG parent or to anyone outside the family home. The impact of parental PG on older children was quite different. Older children were less affected due to greater financial independence, and adult children distanced themselved from their gambling parent to avoid being harrassed for money. The fourth synthesized finding concerned help-seeking behaviour by CSOs. The majority of CSOs had sought help through self-coping strategies which commonly involved taking over the family's finances. They also sought help from a range of pro- fessionals and specialist gambling services. They were reluctant to disclose details of the PG to their friends. With respect to CSOs attempts to encourage the gamblers to seek treatment, there was very little literature that addressed this. The available data suggested many CSOs had made such attempts, which included coercing them to attend PG support groups, challenging their gambling related beliefs, and encouraging them to speak to others about their problem.

Studies included in this review, contained data collected directly from family and

friends themselves, as opposed to data relating to the gamblers' perspectives on their social and family functioning. This is an important distinction, as reported in this review, studies that have compared the perspectives of gamblers and their CSOs in relation to the impacts of PG, suggest an apparent divergence. Problem gamblers appeared to underestimate the negative impact of their gambling on their partners (Cunha et al., 2015; Cunha & Relvas, 2015; Ferland et al., 2008; Lorenz & Yaffee, 1989), and children (Wurtzburg & Tan, 2011).

A third of studies reviewed, involved CSOs who were associated with a gambler receiv- ing help, while the majority of studies did not report the help-seeking status of the gambler. Just three studies (Hodgins et al., 2007; Makarchuk et al., 2002; Nayoski & Hodgins, 2016) deliberatley recruited CSOs associated with problem gamblers who were not receiving help. There is some evidence that family functioning improves when the gambler enters treatment (Boyd & Bolen, 1970; Lee & Rovers, 2008) and that children of problem gamblers receiving help are psychologically healthier than children of problem gamblers not receiving help (Leiseur & Rothschild, 1989). To improve our understanding of the impacts and experiences of CSOs associated with non-help-seeking problem gam- blers, more research carefully targeting such CSOs, is needed (e.g. Bond et al., 2016).

The themes and sub-themes in the present study were generated inductivley, synthe- sizing the findings across all 51 studies, as opposed the beginning with a prior set of potential harms. Through this process we arranged the main themes according to the focus of the selected studies, and sub-themes the potential harm. Though more recently research on gambling harm and affected others has taken a broader approach, examining the types of harm across all CSOs (e.g. Li et al., 2017; Shannon et al., 2017), the bulk of research to date

has focused on a particular group such as partners (e.g. Lorenz & Yaffee, 1989; Mazzoleni et al., 2009; Schluter et al., 2008) or children (e.g. Leiseur & Rothschild, 1989; Wurtzburg & Tan, 2011). The results of this review provide us with a sense of where the research to date has been conducted with CSOs. For example, much more research concerning gambling-related harm has been conducted with partners (more than two thirds of studies) than other CSOs. Future research could consider whether being a friend, child, parent or partner has any impact on how potential harm is experi- enced, and the type of support that would be most beneficial. The types of harm reported across studies from he present review (mental health, risky alcohol/other drug use, phys- ical health, marital conflict/familial violence and financial stress) are largley consistant with categories reported by recent research which has aimed to quantify gambling harm. Shannon et al. (2017) reported seven domains of harm: health, social, critical events, social, employment, finance and psychological. Interestingly, leisure (withdrawal of leisure activities by CSOs) was among their top five weighted harms, yet did not arise as a gambling harm sub-theme in our synthesis. This suggests that though this particular harm is important, there is very little research in this area. Similarly, employment did not emerge from our synthesis. Employment was a domain also derived from Li et al. study (2017) which presented six domains of harm (financial, work/study, health, emotional/psychological, relationships and other). That this harm did not emerge from our synthesis, suggests that affected others' reduced performance and or related absence from work/study, is also an area lacking in research.

Limitations

This review has several limitations. Firstly, only peer-reviewed studies written in English were included. Information from books, conferences, unpublished work or grey literature was

not included. Secondly, only a small number of studies reported recruiting CSOs associated with non-treatment-seeking problem gamblers, which potentially presents a sampling bias. A third limitation concerns the lack of attention to researchers' possible influences and biases among the qualitative studies. A fourth limitation concerns a response bias among most studies, in that the vast majority involved samples containing substantially higher proportions of female CSOs. A fifth limitation concerns the inclusion criteria used for the present research, requiring all articles to be published in peer reviewed journals. As such, there may have been relevant studies in the grey literature which were not included, such as reports by Gambling Research Australia. One such study is Dowling, Jackson, Thomas, and Freydenberg's (2010) research which found children raised in families exposed to PG, were vulnerable to developing gambling problems. Though that particular study was not included in our review, the issue was picked up in Jacobs' et al. (1989) study. Finally, despite conducting a wide-ranging systematic search, there is always the chance that some pertinent studies may have been overlooked. These limit- ations should be taken into account when interpreting the results of this review.

Conclusion

Notwithstanding the stated limitations, this systematic review provides a comprehensive coverage of the empirical literature on gambling-related harm and affected others. It is clear that the impact of PG is widespread and has significant negative effects on partners, children and parents. Partners are especially impacted, suffering both mental and physical health problems. Children are also particularly effected and appear to suffer silently due to their reluctance to disclose their parental PG worries. Problem gambling treatment and couselling services should take into account the pervasiveness of the impacts of PG and be equipped to

respond appropriatley to the needs of CSOs. Due to the response biases that emerged through reviewing this literature, future research should focus on male CSOs, and CSOs associated with non-help-seeking problem gamblers. Focused research on CSOs' withdrawal from leisure activities and the impact on work/study is also needed.

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Pubmed	gambl*[tw] AND (family*[tw] OR families[tw] OR familial[tw] OR parent*[tw] OR mother*[tw] OR father*[tw] OR child*[tw] OR grandparent*[tw] OR sibling*[tw] OR “concerned significant other*”[tw] OR partner*[tw] OR spous*[tw] OR wife[tw] OR wives[tw] OR husband*[tw] OR marital*[tw]) AND English[la]
Scopus	TITLE-ABS-KEY (gambl* AND (family* OR families OR familial OR parent* OR mother* OR father* OR child* OR grandparent* OR sibling* OR "concerned significant other*" OR partner* OR spous* OR wife OR wives OR husband* OR marital*)) AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re") OR LIMIT-TO (DOCTYPE , "ip"))
PsycINFO	(gambl* and (family* or families or familial or parent* or mother* or father* or child* or grandparent* or sibling* or "concerned significant other*" or partner* or spous* or wife or wives or husband* or marital*)).ti,ab,sh.

Figure 1. Search terms used for systematic review.

Notes. [tw] = search on title, abstract and Medical Subject Headings (MeSH) fields; TITLE-ABS-KEY = search on title, abstract and keywords fields; Ti = title; ab = abstract; sh = subject heading search.

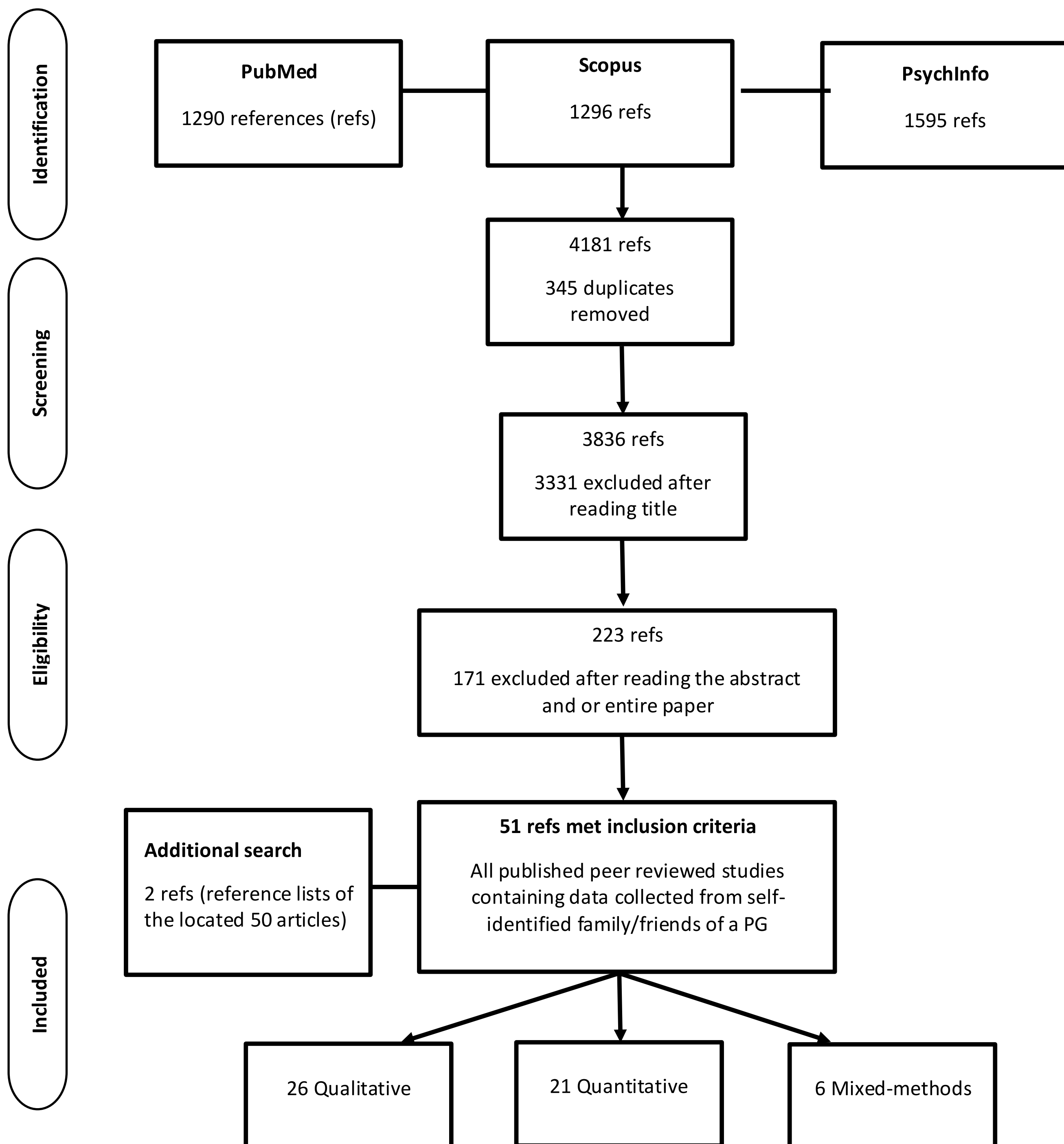

Figure 2. Flowchart of selection of articles according to PRISMA.

Table 1. Themes and sub-themes

Themes	Sub-themes
Impact on CSOs' health (partners)	Mental health Risky alcohol and or other drug use) Physical health
Impact on the marital/couple dyad	Hypervigilance Conflict including familial violence Financial stress Comorbid alcohol and or drug use by the gambler
CSOs other than partners	Children Parents
CSOs help-seeking behaviour	Seeking help for themselves Seeking help for the gambling (including encouraging the gambler to seek treatment)

Appendix 15. Qualitative study 1; published paper

Appendix 15.

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Harm Reduction Journal

RESEARCH Open Access

Understanding the business versus care paradox in gambling venues: a qualitative study of the perspectives from gamblers, venue staff and counsellors

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Abstract

Background: In recent years, greater emphasis has been placed on gambling venues to identify potential problem gamblers, respond appropriately and refer to treatment. In seeking the perspectives of problem gamblers, venue staff and treatment providers, this qualitative study investigates how problem gamblers experience being identified and referred for treatment by venue staff.

Methods: A semi-structured interview guide focusing on experiences and perceptions of problem gambling identification and referral for treatment in gaming venues was used to conduct 4 focus groups and 9 semi-structured in-depth interviews. Participants comprised 22 problem gamblers, 10 gambling venue staff and 8 problem gambling counsellors. Audio recordings were transcribed verbatim, and an interpretive phenomenological analysis was conducted.

Results: 'Role conflict' was identified as a considerable source of stress for venue staff who described conflicting priorities in responding to problem gamblers whilst maintaining employer profit margins. Problem gamblers described offers of help from venue staff as hypocritical and disingenuous. Venue staff also described reluctance to make moral judgements through the identification of and engagement with problem gamblers, and gamblers described resentment in being singled out and targeted as a problem gambler. Being approached and offered referral to a counselling service was a rare occurrence among problem gamblers. This corresponded with reports by gambling counsellors.

Conclusions: Role conflict experienced by gambling venue staff and patrons alike inhibits effective referral of potential problem gamblers into treatment. Reducing the need for gambling venue staff to make a perceived moral judgement about the gambling behaviours of specific patrons may improve the reception of responsible gambling information and promote help-seeking.

Keywords: Problem gambling, Qualitative, Venue staff, Role conflict, Identification

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Background

Australia has the highest gambling participation rate [1] and among the largest number of electronic gaming machines per capita in the world [2]. An estimated 2.5% of Australian adults experience moderate to severe problems caused by problem gambling (PG) [1]. For every problem gambler, around six others such as partners and children are also adversely affected [3] suggesting up to four million Australians can experience emotional, social and financial stress caused by PG. Despite this, studies from Australia and the USA report only a small number of problem gamblers seek help [1, 4], and for those that do, help-seeking is often a last resort after experiencing significant negative consequences [1, 5].

Given the general reluctance of individuals with gambling problems to seek help [5–8] and reported low levels of awareness of help services among problem gamblers [8], gambling venues provide a valuable opportunity for staff to inform gamblers of available help services and offer referral. Consequently, gaming room resources and staff interactions with gamblers may have important public health implications, particularly, as venue staff are among the first point of contact for individuals looking for help with gambling problems [1]. Furthermore, there is some evidence that as gamblers develop rapport with the staff and view them as trustworthy [1]. Frontline gambling venue staff therefore could provide an important gateway to encourage problem gamblers to seek treatment and to facilitate referrals [9]. As such, there has been increased interest in the degree to which gambling venue staff can identify problem gamblers and take an active role in intervening before further harm is endured [10].

A number of studies have found venue staff feel confident in their ability to identify problem gamblers [11–13]. However, the only study to date which has examined staff accuracy in PG identification found that venue staff were able to identify only 36% of patrons experiencing problems with gambling. Many gamblers who self-reported at least moderate gambling problems were not classified as having any problems by staff. On the other hand, a number of gamblers in the 'no risk' category were classified by staff as having problems [14].

There have been several attempts to develop behavioural checklists to assist venue staff in identifying problem gamblers [15–17]. These studies suggest that a range of visible and non-visible cues, when occurring in combination during a visit, have a high confidence value in identifying someone as a problem gambler. However, the authors point out that the relatively low frequency that behavioural indicators are likely to occur, at the precise time a single onlooker might observe them, poses significant challenges for effectively using such indicators in practice [16]. Delfabbro et al. [10] argued that whilst staff may be able to observe potential indicators, this would require a period of continuous observation that would likely be impractical for staff to perform, given their other competing duties. These outcomes are consistent with the conclusions provided by Schellinck and Schrans [16] and Allcock [18], in that although it is theoretically possible to identify problem gamblers using a range of behavioural indicators, there are many challenges facing venue staff if they are to rely on such indicators in practice.

In addition, staff have identified role conflict and role ambiguity as significant sources of stress [19] given on the one hand they have the role of attracting patrons, whilst at the same time there is an expectation that they approach patrons of concern, which may ultimately lead to driving the patron away to another hotel [9]. A contradiction exists in that venues, as businesses, are motivated to generate profits, whilst concurrently required to discourage problematic gambling, despite the fact that in Australia, problem gamblers contribute 40% of all money put into electronic gaming machines [1]. To date, this 'business versus care' paradox has received little empirical attention.

With a greater emphasis being placed on gambling venues to identify and respond to potential problem gamblers, further research is needed that focuses on how venues can best respond to potential problem gamblers to effectively facilitate harm reduction. This paper aims to address this gap by presenting a qualitative analysis from a sample of problem gamblers, gambling venue staff and gambling counsellors' perspectives on the identification and response to PG in venues.

The present research seeks to examine the help-seeking experience in the context of gambling venues, from the perspectives of problem gamblers, gambling venue staff and gambling counsellors, and how such experiences affect responding to PG in venues. Our aim is not just to describe the experience of identification and response from the perspective of gamblers and staff, but to understand the phenomena at a deeper level [20], taking into account the various challenges, such as stigma and role ambiguity, reported by previous research. This study aims to understand this phenomenon and provide suggestions to improve effective engagement of problem gamblers in the venue. Based on these aims and objectives, the following research questions were developed for this study:

- What is the lived experience and meaning to be a gambling venue staff member in a climate of responsible gambling?
- What is the lived experience and meaning to be a problem gambler in a gambling venue in a climate of responsible gambling?

- What are the perspectives of PG counsellors concerning policies that encourage them to engage with gambling venues?
- How can gambling venues effectively facilitate help-seeking among problem gamblers?

Qualitative research is particularly helpful in providing rich descriptions of complex phenomena [21]. The primary method used in this study was interpretive phenomenological analysis (IPA) as described by Smith and Osbourne [22] utilising a Heideggerian philosophical perspective. IPA is concerned with examining how individuals make sense of their experiences [23]. Heideggerian phenomenology views that our experience always occurs and is made sense of within a situated context [24]. Therefore, an experience cannot be simply lifted from an individual's consciousness. Rather, to understand the meaning of an experience to an individual, the researcher must engage and interpret the individual as they themselves interpret and make sense of their own experience. This two-staged analytical process of studying experience is described by Smith and Osborne [22] as a double hermeneutic, which can be useful for discovering meaning which may be hidden due to the phenomena's mode of appearing [24].

Methods

Within the iterative project design, there were two distinct phases of data collection. The first data collection phase involved conducting focus groups with the following stakeholders: problem gamblers in treatment (focus group 1), gaming venue staff (focus group 2), consumer advocates with lived experience of PG (focus group 3) and gambling help service counsellors (focus group 4).

Focus groups are used to collect specific types of information from clearly identified groups of individuals [25]. They have an advantage over individual interviews in that the group setting provides a more social environment, as participants influence and are influenced by others—as they are in real life [26]. This is particularly useful when the phenomena of interest involve individuals making decisions that are made in a social context. For instance, a decision by venue staff to approach a patron and initiate referral to a gambling help service is made involving discussion with other staff. Therefore, examining this process in a group setting provides a useful medium to obtain rich and valid data. An iterative process was employed whereby data from each focus group were analysed, before subsequent groups were conducted. Data from former groups were revisited before moving onto the next, and emerging insights helped inform the semi-structured questions used for the focus groups that followed. Whilst focus groups do have some limitations [26], it was decided that this was the best way to explore initial themes, which could be followed up by in-depth interviews.

In line with the iterative nature of the study, findings from the focus group analyses then helped to determine the most important questions to follow up in the in-depth interviews conducted in the second phase of data collection with problem gamblers. This provided an opportunity to follow up on emerging themes and insights and to examine these from other target group perspectives, in addition to uncovering new themes as they emerged.

The second data collection phase involved conducting a series of semi-structured individual in-depth interviews with the following two groups: Aboriginal and/or Torres Strait Islander individuals impacted by PG, problem gamblers attending PG counselling. These two groups were purposefully chosen based on themes that had emerged from the stage 1 focus group analyses. The aim of this second phase of data collection and analyses was to investigate emerging themes in greater depth.

In-depth interviewing involves conducting intensive individual interviews with a small number of participants to explore their perspectives on a particular idea, programme or situation [27]. Interviews were semi-structured to allow the interviewers some control over the direction of the content to be discussed, whilst allowing participants to elaborate or take the interview in new but related directions [27].

Target population and sampling techniques

A mixed purposeful sampling method combining three different strategies (maximum variation, expert, homogenous) that were considered most consistent with the research purpose was used to recruit participants across all focus groups and in-depth interviews. Purposeful sampling is used in qualitative research to select information-rich cases related to the phenomenon of interest [28]. The purpose of this method of sampling is to gain a deeper understanding of the phenomena of interest, rather than to generalise findings to a wider population [29].

Table 1 presents the target population, sampling techniques and procedure for the four focus groups. A purposeful maximum variation method was used for groups 1 and 4 (problem gamblers, counsellors) to gain a wide range of age, gender and sociodemographic variation among problem gamblers, along with a group of counsellors from a range of different organisations. Problem gamblers were current clients of two local gambling help services. A senior staff member of each service contacted suitable individuals and invited them to participate in the study. To recruit counsellors, managers of six distinct gambling help services approached suitable participants and invited them to participate in the study.

Table 1 Target population, sampling techniques and procedure for focus groups

Focus group	Target population	Sampling technique	Location	Group facilitator	Group observer
1	Problem gamblers in treatment	Purposive maximum variation	University campus conference room	PhD student experienced with focus groups	PhD student experienced with PG counselling
2	Gambling venue staff	Purposive expert	Hotel boardroom central to city	PhD student experienced with focus groups	PhD student experienced with PG counselling
3	Consumer advocates with lived experience of PG	Purposive expert	Meeting room at local GHS	PhD student experienced with focus groups	PhD student experienced with PG counselling
4	GHS counsellors	Purposive maximum variation	University campus conference room	PhD student experienced with PG counselling	Senior research fellow experienced with focus groups

GHS gambling help service

For groups 2 and 3 (venue staff, consumer advocates), purposeful expert sampling was used, to target venue staff with experience in approaching potential problem gamblers, which are predominantly the managers of gaming venues, and a local consumer advocate group was targeted to access individuals with lived experience of PG who had good knowledge of local gaming room policies and procedures. To recruit venue staff, a representative from the Australian Hotels Association approached suitable individuals and invited them to participate in the study. All interview guides were semi-structured. Groups 1 and 3 focused on gamblers' journey to help-seeking, experience with venue staff interacting with them around PG, experiences with the Gambling Help Line and experiences with gambling help materials in the venue. Group 2 (venue staff) focused on experience with interacting with patrons of concern, experience with available responsible gambling materials in the venue and experience with interacting with patrons of culturally diverse backgrounds in concerning PG. Group 4 (counsellors) focused on experience of PG clients talking about their interactions with hotel staff, experience with the available support and help materials in the venues and experience regarding their clients' use of responsible gambling material in venues. Prior to conducting the focus groups, two researchers spent time in the field observing the gambling venue environment and interactions between staff and patrons. Reflective memos were made which were later used to enhance and inform the interpretive analysis process. A dynamic analysis process was achieved with observation of environment and participant interactions, reflection by both researchers in situ and analysis of the actual transcribed data. Table 2 presents the final makeup of the focus groups. Each focus group was conducted by two researchers: one facilitated the interview; the other operated the recording device and took detailed observational notes which included any remarkable pauses, gestures and speech dynamics [30]. Immediately following each focus group, the two researchers discussed any notable elements of the group content and their own experiences. These debriefing sessions were digitally recorded and professionally transcribed and incorporated into the analyses. Based on the initial analysis of focus group data, both purposeful maximum variation and purposeful homogenous sampling were used to recruit participants for the in-depth interviews. From the focus group data, venue staff and counsellors spoke of challenges they experienced engaging with Aboriginal gamblers. This was an issue we wished to follow up; hence, we wanted good variation among problem gamblers in treatment along with targeting a number of First Nations people with lived experience. Five participants of Indigenous Australian background were purposely selected, and a further six participants were recruited from two metropolitan-based PG help services via counsellors. The semi-structured questions for the in-depth interviews explored participants' journey to help-seeking; the influence of important people in the participant's decision to seek help; the influence of participants' cultural background on their decision to seek help; participant's experience with responsible gambling messaging, particularly concerning their journey to help-seeking; and experience of venue staff concerning help-seeking.

In total, 11 in-depth interviews were scheduled with individuals with lived experience of PG. Nine interviews were conducted as two individuals did not attend their scheduled interview. These individuals were subsequently followed up and, in order to accommodate their work schedules, offered phone interviews but they declined to participate. The interviews were conducted by the PhD students who collected the data in phase 1. The interviews were carried out at locations convenient for the participants and included a university office, the office of a PG help service and the two specialist services. Table 3 presents the characteristics of individuals who participated in the in-depth interviews.

Data analysis and verification procedures: revealing the phenomenon

With participants' consent, all interviews were digitally recorded. Recordings were then professionally transcribed

Table 2 Sample characteristics of 32 focus group participants

Characteristics	Participants
Focus group 1: problem gamblers, $n = 8$	
Gender	
Male	2
Female	6
Age	
18–39	0
30–39	7
40–49	1
50–59	0
60+	0
Length of time having a gambling problem	
Less than 12 months	1
1–2 years	1
2–5 years	1
5–7 years	1
7–10 years	1
10+ years	3
Marital status	
Married/de facto	2
In a relationship	1
Separated/divorced	2
Widowed	0
Single	3
CALD background?	
Yes	2
No	6
Employment status	
Employed full time	6
Employed part time	1
Unemployed	0
Retired	0
Home duties	0
Disability pension	1
Student	0
Focus group 2: venue staff, $n = 10$	
Age	
18–39	1
30–39	5
40–49	1
50–59	3
60+	0
Length of time working in a gaming venue	
Less than 12 months	0
1–2 years	0
2–5 years	0
5–7 years	1
7–10 years	3
10+ years	6
Marital status	
Married/de facto	2
In a relationship	3
Separated/divorced	1
Widowed	0
Single	4
CALD background?	
Yes	0
No	10
Employment status	
Employed full time	7
Employed part time	0
Employed casually	3
Focus group 3: consumer advocates, $n = 7$	
Gender	
Male	4
Female	3
Age	
18–39	0
30–39	0
40–49	4
50–59	3
60+	0
Length of time having a gambling problem	
Less than 12 months	0
1–2 years	0
2–5 years	2
5–7 years	1
7–10 years	1
10+ years	3
Marital status	
Married/de facto	6
In a relationship	1
Separated/divorced	0
Widowed	0
Single	0
CALD background?	
Yes	3
No	4

Table 2 Sample characteristics of 32 focus group participants *(Continued)*

Characteristics	Participants
Employment status	
Employed full time	1
Employed part time	3
Unemployed	0
Retired	2
Home duties	0
Disability pension	1
Student	0
Focus group 4: problem gambling counsellors, $n = 7$	
Age	
18–39	0
30–39	4
40–49	2
50–59	1
60+	0
Length of time working as a problem gambling counsellor	
Less than 12 months	1
1–2 years	1
2–5 years	2
5–7 years	1
7–10 years	1
10+ years	1
Marital status	
Married/de facto	6
In a relationship	1
Separated/divorced	0
Widowed	0
Single	0
CALD background?	
Yes	3
No	4
Employment status	
Employed full time	5
Employed part time	2

CALD culturally and linguistically diverse

Table 3 Sample characteristics of nine in-depth interview participants

Characteristics	Participants
Gender	
Male	4
Female	5
Age	
18–39	0
30–39	1
40–49	3
50–59	3
60+	2
Length of time having a gambling problem	
Less than 12 months	0
1–2 years	1
2–5 years	3
5–7 years	2
7–10 years	2
10+ years	1
Marital status	
Married/de facto	3
In a relationship	1
Separated or divorced	2
Widowed	0
Single	3
CALD background?	
Yes	6
No	3
Employment status	
Employed full time	1
Employed part time	1
Unemployed	0
Retired	1
Home duties	2
Disability pension	4
Student	0

CALD culturally and linguistically diverse

and checked for accuracy by two researchers. Due to a technical failure, one in-depth interview audio recording was not made, and thus, a transcript was not produced. This failure was detected immediately after the interview was complete, and thus, the researcher was able to make detailed field notes about the specific content of the interview, including verbatim quotes. Transcripts were uploaded into NVivo 11 qualitative data software tool [31]. In line with the two phases of data collection, there were two corresponding phases of data analyses. The analytical guidelines for IPA as recommended by Pietkiewicz and Smith [23] were applied. Firstly, audio recordings from the focus groups were listened to and the verbatim transcriptions read multiple times independently by two researchers. At this stage of the analysis, the focus was directed to what the text was saying [32]. Individually, the researchers made initial interpretive exploratory notes during readings which they transformed into potential emergent themes. The researchers then met to examine

connections between potential themes and group them together according to conceptual similarities. The same process was then applied to the phase 2 in-depth interview dataset. Next, all transcripts were phenomenologically coded and phenomenological clusters developed. Data from the group facilitators' debriefing sessions and observational notes were included at this stage of the analyses, to assist with interpretation of the text. As the text was read and re-read, individual parts of the text were interpreted in the context of the whole dataset. Continual movement between the parts and the whole (the hermeneutic cycle) led to a deeper understanding of the text and allowed us to move from an understanding of what the text was saying to understanding of what it talked about. 'The sense of a text is not behind the text, but in front of it. It is not something hidden, but something disclosed' [32], p87. For example, text noting how venue staff were fearful of a negative response from gamblers if they approached them with concern was initially interpreted as a fear of gamblers who may be angry about losing their money. Further engagement with the text, supported by observation and reflection on participants' expressions and body language, and the researchers' interpretation of what these processes meant however, resulted in a deeper understanding of the aforementioned fear. The insight that emerged was that the fear stemmed from staff perceiving they were being hypocritical by encouraging patrons to gambling on the one hand and then discouraging them if the gambled too much, and gamblers were aware of this perceived hypocrisy and could react adversely. This careful analytical process led to a final list of interpretive superordinate and subthemes. Following the analyses of the focus group and in-depth interview data, findings were combined to enhance data richness. Use of such methodological triangulation provided diverse ways of looking at the same phenomena and enhanced credibility by strengthening confidence in conclusions derived [33, 34].

Results

The characteristics of the sample for the focus groups and individual interviews are shown in Tables 2 and 3. A total of 41 participants (13 male) comprised four separate focus groups and nine individual in-depth interviews. The majority of participants (68%) were aged between 30 and 49 years and either married, de facto or in a relationship (64%).

Themes emerging from the data

Initial readings of the interviews provided the impression that harm reduction policies in the gaming room created a particularly stressful environment for staff. Furthermore, gamblers (who were largely unaware of such policies) and counsellors did not believe it was in the venues' interest to implement them rigorously. Early in the analysis, an enormous amount of data was produced concerning individual experiences and perspectives. Through application of the hermeneutic cycle (with rich discussion supported by detailed reflective memoing by the two researchers and further debate and discussion by the broader research team to support rigour in data interpretation), the following insights emerged. Although subjective experiences of the phenomena were presented differently in the text, shared meanings were uncovered across the focus groups and individual interviews. Six themes were revealed through the focus group data which were supported by the in-depth interviews. The in-depth interview data led to the extension of one theme and the emergence of another, resulting in seven themes. Most notably, perceived stigma significantly influenced gamblers' help-seeking behaviour, which tended to be when they had reached crisis point. A personal connection with trusted venue staff was paramount for an effective interaction around PG. The perceived divergence of gaming room staffs' hospitality duties and responsible gambling obligations was a discrepancy experienced from many perspectives across focus groups and in-depth interviews and hindered interactions between gamblers and staff. As the purpose of this research was to examine the help-seeking experience in the context of gambling venues from several perspectives, quantification (e.g. frequency counts) was not undertaken. To illustrate the themes that emerged, relevant examples from the discourse are presented.

Personal connection

Personal connection related to the importance of rapport between problem gamblers and gaming venue staff, gaming venue staff and gambling help service staff, and problem gamblers and gambling help service staff. A genuine and personal connection was crucial between venue staff and patrons for both the staffs' willingness and confidence in initiating engagement with patrons around their level of gambling and for acceptance of such interactions by patrons. In addition, a personal relationship was highlighted as being of principal importance between staff of gaming venues and gambling help service staff. A close working relationship between the two parties was viewed as essential for creating an environment in which effective referrals could take place. Such a relationship would also provide support for venue staff and compliment the work of the hotel and club's responsible gambling early intervention agency teams. Rapport was generally built over time, as indicated by the following participant response:

> I wouldn't be here today if it wasn't for one of the people in the venues. She didn't approach me outright. She just kept an eye on me, and she'd come around, just quickly, say, 'Oh how are you today?' and slowly I got to know her, and with the problems I had I started to confide in her, and on my own bat, I rung

up the help, and that's how the staff, I couldn't thank her enough, because it changed my life. But like I said, the venue people, they try, but all depends how you click with them, I think (Female participant, focus group 1).

A close working relationship between gaming venues and gambling help services would also provide opportunities for feedback for staff regarding outcomes of patrons referred to help services, which was reported as one factor that might further encourage referrals. The personal connection theme also related to PG participants' negative experiences with the national gambling telephone helpline and the lack of information about local support services. This was particularly relevant for culturally diverse populations, though a number of Aboriginal participants explained that they would be reluctant to seek help regardless of a good relationship with staff or awareness of services:

We're supposed to be strong in culture, strong Aboriginal women, and we do it all on our own. We grew up to be like that (Female participant, in-depth interview).

Role conflict

A perceived conflict between venue staffs' hospitality duties and responsible gambling obligations was a discrepancy experienced from many perspectives across all groups. Though not visible initially, multiple readings of the text moving continuously between the parts to the whole allowed this theme to be revealed across the whole dataset. Venue staff described experiencing a distinct conflict between expectations to create a comfortable environment for patrons to gamble in, whilst at the same time being mindful of their obligations to monitor patrons' spending and to intervene if necessary. This issue received much attention in the focus groups and was clearly a source of stress for venue staff, who at first were reluctant to talk about it. It took around 15 min of informal discussion and long periods of silence before staff began to speak openly about this issue. Once they began, however, their tone became more animated and pronounced as they heard other group members share similar experiences. Participants were visibly torn, frustrated and agitated when describing harm reduction in the context of their duties. Staff were conflicted with the divergence between business and care, as illustrated by the following exchange:

There's a very fine line between running a business and caring about your patrons. And I think that's the hardest thing with every person that works in gaming, is that if you remove a big punter and your senior sees that, they go 'what are you doing, you're ruining our income'. Well hang on, I have a duty of care to my patrons, where's the line? (Female participant, focus group 2).

Problem gambling participants described being acutely aware of such conflict of roles, which led to any approach by concerned venue staff, being perceived by gamblers as disingenuous or hypocritical. Though many of the gamblers spoke about their desperation for help, they clearly viewed venue staff as promoters of gambling, which significantly hindered any well-meaning harm reduction interactions. The researchers noted the resentment from the gamblers during focus groups 1and 3 (gamblers) when venue-driven harm reduction strategies were discussed and made the comment that gamblers appeared to take particular offense to the perceived hypocrisy.

They've got a conflict of interest. It doesn't work if its direct staff. You've got management that – they want to keep people there that spend big money. There is a conflict. (Female participant, focus group 1).

Yeah. You know that they don't care. (Male participant, focus group 1).

This perceived hypocrisy also impacted on participants' preference regarding help-seeking, which was best exemplified by the following comments:

Well it's not to the pub's advantage to tell people to leave and not gamble, is it? For me, I wouldn't use it (gambling help information and support) if it was in the pub. It seems almost hypocritical, you know what I mean? (Male participant, in-depth interview).

Counselling staff also described their experience interacting with venue staff around role conflict.

I've had a few come up and take my card and rang and said that they were quite stressed about the sort of position that they were in around having to have these responsible gambling checks, but also not being able to do a lot of the reporting in the way like perhaps approaching people for reasons around not feeling that they would get the backing of management. So I think people (venue staff) learn to manage the stress of working in that really conflicting role that they're in by turning a blind eye. (Female participant, focus group 4).

An initial reading of the following comment gave the impression that staff viewed heavy gamblers as 'out of control addicts' who could become aggressive

if interrupted. However, re-reading the text, moving between the parts to the whole, revealed that staff felt they were constantly shifting between being a hospitality worker and a counsellor or private investigator, with the latter raising the risk of an adverse response from patrons. Venue staff described feeling they were being forced to make a moral judgement in identifying patrons who were deemed to be overspending. This influenced their reluctance to approach patrons and at times involved a level of fear concerning how patrons might respond.

> But then at what point did our job descriptions include private investigator?
>
> (Female participant, focus group 2).

> So I feel that even though we do record and we do speak to them, you've got to be careful want you do say and when you do speak to them, because quite often they can be quite aggressive. And you're putting yourself into danger in that reason. I've come up to a few aggressive ones. (Female participant, focus group 2).

Venue staff explained they would feel much more comfortable and willing to provide responsible gambling-related educational material (information about the nature of gaming machines, details of available help services) to all patrons irrespective of their level of gambling, as it removed the need to make a perceived moral judgement. The following comment illustrates this sentiment which was echoed by gamblers in focus groups 1 and 3.

> Maybe like if I was trained and I went up to every customer and said 'I'm the duty manager here, I've been trained, this is my new responsibility to advise everybody of the service available if you ever feel like you have a problem'. And if you're doing it to everybody, no one is going to feel singled out. So that could kind of get rid of a bit of that issue where if you go up to somebody. (Female participant, focus group 2).

The tipping point to help-seeking is individualised

The majority of PG participants indicated their help-seeking was associated with a point of crisis, such as loss of employment, getting 'caught' or the gambling problem becoming disclosed or going through a divorce. Help-seeking at this point typically involved phoning the Gambling Help Line or approaching venue staff to initiate a self-barring order. This theme was also based on the shared experience among venue staff of the tendency to initiate contact with a patron of concern only if they displayed overt signs of distress. An initial reading of the following comment gave the impression that staff believed at times feeling as though the entire gaming room was full of problem gamblers and that it was not feasible to intervene with them all. However, through a deeper engagement with the text, it became clear staff found themselves in a difficult position in that they were required to consider which gamblers could afford to lose their money. This was described as a highly individualised and private matter. Staff also felt pressure in making a moral judgement and their concerns about incorrectly approaching a patron who did not have a problem, that is, making a false positive identification. Consequently, they tended to wait for overt and/or disruptive behaviours before initiating an approach.

> I think the room is full of a lot of problem gamblers, but then I think it's easier to identify when there's a real, real problem. Do you know what I mean? I think we're surrounded by problem gamblers. (Female participant, focus group 2).

> Because she's a doctor, and she comes in after – she obviously works all night and then she comes in first thing in the morning when she's finished...everyone's done like a gaming report on her, and we do believe what she says is true, that she does have enough money. (Female participant, focus group 2).

Through the in-depth interviews, it emerged that what constituted a motivator for help-seeking was different for each person and that the 'tipping point' existed on a continuum. The majority of in-depth interview participants described accessing help well before experiencing a significant crisis. One male participant reported accessing help when 'I was getting close to my moral line'. Some participants explained that they were dismissive of gambling help services and responsible gambling material, as they did not view themselves as problem gamblers. However, some of these same individuals reported accessing help at some point when information was offered, before reaching what might be described as a significant crisis. As such, some individuals though not acknowledging they might have a problem chose to access help when information was offered at various points prior to reaching a state of crisis. Such points included accessing help for co-morbid mental health and substance use issues.

Discretion and privacy

Across all focus groups, discretion and privacy were considered paramount in the effective facilitation of

help. This related to both the timing and location of interaction between venue staff and patrons and to the physical placement of responsible gambling messaging and gambling help service information within the gambling establishment. Accessing gambling help information was described as an extremely difficult thing to do. One gambling counsellor reported 'I've had clients tell me that it's too embarrassing to pick up information, that they wouldn't do it'. Problem gambling participants indicated the responsible gambling materials in the gaming rooms were largely ineffective, because they were not in a clear frame of mind whilst gambling. A number of participants spoke of signage they had seen in the bathroom and explained that this particular material had been effective for two reasons. Firstly, they were able to read the information in a private place. Secondly, they were away from the gaming room and in a clearer mindset, which allowed them to be more open and receptive of responsible gambling information. The following exchange by group members reveals this point:

> What has made me think about my gambling when I've been gambling, is if they've had a large advert of seeking help or what are you doing? The men's toilets had a sign on the door as you go in or as you come out. I think there was even one over the urinal from memory, if I could use that expression, and it did make me think what I was doing. (Male participant, focus group 1).

> The stuff that's in the gaming room, I bet you it's there, but we don't see it, or we didn't see it, because you deny. You're in denial for a long time. (Female participant, focus group 3).

> When you go sit down on the toilet and shut the door, it's the same as females with pap smears (laughs). (Female participant, focus group 1.)

> You're away from the machine so you've got time to read something. (Male participant, focus group 1).

Privacy was of particular importance among Aboriginal participants, who described a reluctance to seek help under almost any circumstances. This was due to both significant shame and embarrassment and a belief that they were responsible for their problem and should therefore be responsible for resolving it alone.

> We don't like to put ourselves out there. If we've done something wrong, we don't want to have to admit that, I suppose. Aboriginal people, we do get really embarrassed about stuff like that, but that's why we don't always say stuff. We just keep it close to us because we're ashamed of it. (Aboriginal Male participant, in-depth interview).

Shame and embarrassment were very common experiences among gamblers and resulted in them keeping their problems secret. As the text was read and re-read with continuous movement between individual responses and the dataset as a whole, what emerged was an understanding that privacy had a particular effect for Aboriginal respondents. Not talking to anyone about their problem led to a feeling of isolation and a perception that they were the only ones that felt ashamed. This is best exemplified by the following comment:

> I think Nunga people think that they are the only ones that feel that way but they're not the only ones. Just like when white people first came here, they thought we were animals. We all feel the same way. It's not until 150 years later where we are acknowledged as human beings. We are just the same, we just feel like we are the only ones that are ashamed of behaviour. (Aboriginal female participant, in-depth interview).

Organisational inconsistencies

Problem gambling participants expressed frustration that they could self-bar themselves in one venue then walk across the road to another and continue gambling. This was echoed by venue staff who expressed frustration that due to privacy issues, they could not share information about patrons of concern with neighbouring venues. This led to a feeling of apathy among venue staff in that barring or approaching a patron of concern around their excessive gambling may not in fact reduce any harm, as the patron may merely attend another nearby hotel.

> Because like this lady – well most of our customers, if they're barred, what they're going to do is walk down the end of the road, cross over and there's another one (Male participant, focus group 2).

> She's just down the road. She's like 200 metres down the road at the next pub. And it's like, well it's just ridiculous. (Female participant, focus group 2).

In these above two comments, it was clear that the participants were frustrated. They had previously discussed how stressful it was to approach a patron of concern about their level of gambling. They explained that even if they did raise the courage to engage the gambler, the gambler would just go and continue gambling at another venue.

Problem gambling participants suggested that multiple and frequent non-threatening approaches by concerned staff across numerous venues would be more effective in encouraging them to seek help, even if the approaches were not received well at the time, than a penultimate contact initiated by a 'red flag' incident when a patron displays overt signs of distress. The 'inconsistencies between organisations' theme was also based on the experiences of PG help service staff who reported that some agencies were much more active in fostering relationships with local gambling venues than others. Also within this theme was the inconsistency between venues in the type and manner of PG help service information that was made available to gamblers. The organisational inconsistencies theme was supported also via in-depth interview data, regarding the inconsistent application of barring orders by venues. One participant living in an inner rural city discussed their experience of one venue being highly vigilant in upholding the barring order and refusing entry and the opposite experience in another venue close by.

Lack of awareness

Problem gambling participants and gaming venue staff expressed a general lack of awareness of the available support services for individuals struggling with gambling issues. Other than the Gambling Help Line, participants were largely unaware of the range of available specific services and the nature of the assistance they provided. This theme was also based on PG participants' lack of awareness of the responsible gambling training that venue staff must undertake. In addition, gamblers were unaware of venue staffs' obligations around monitoring patrons' spending habits and their duty to identify potential patrons of concern and intervene as necessary. In fact, one participant reported their lack of awareness that staff were able to offer a suite of options for patrons experiencing difficulties with their level of gambling and was of the belief that venue staff could only assist by facilitating a barring order. This reduced the likelihood of them approaching venue staff for help.

> I didn't know how staff would be able to help me, and the only way that I thought that they could help me was to bar me, and I didn't want to be barred. (Female participant, focus group 1).

A number of other participants agreed with this and noted that this attributed to patron reticence to approach staff, unless they wanted to action a self-barring order.

> Now, nowhere in the gaming venues does it tell you the staff have the information to direct you to the right organisation. (Female participant, focus group 1).

Relapse: a hidden and common experience

This theme emerged through a deeper understanding of the help-seeking process which emerged through the in-depth interviews. With insights gained through these interviews, we re-engaged with the focus group text and continued the interpretive process. It became clear that many gamblers made the decision to stop gambling well before they accessed formal help. They made many attempts to stop and saw each relapse as a failure, which ironically, made them less likely to seek help. A number of participants explained that although they had accessed help at some point, they were very reluctant to access help again following a relapse of their gambling behaviour. One female participant explained:

> I have had the help before and it's great but I think you sort of feel like you don't want to go back there because you've broken your own sort of rules.

There was significant shame around relapse, with one participant stating they were surprised when they learned that many problem gamblers relapse. The shame and self-stigma around perceived failure inhibited appropriate help-seeking. This is highlighted by the following participant's statement:

> Well, you've got to face the person that you've sat with for quite a bit of time and discussed it with and you know in your own head that everything you've said is right, you know, and no, it's not comfortable. It doesn't feel comfortable coming back and saying, 'Hey, I played the pokies again. I failed' you know? (Male participant, in-depth interview).

Discussion

This study aimed to examine the experience of identification and response to PG in venues, through qualitative analysis of the perspectives of problem gamblers, gambling venue staff and gambling counsellors. The results of this research may provide an insight into how gambling venues could effectively help facilitate help-seeking among problem gamblers. That being said, notably, the findings also seriously question whether gambling venues and their staff are in fact a suitable means for

harm reduction. Given that almost half of gaming machine revenue is generated from problem gamblers, this is an important question and we hope this study will encourage researchers and policy makers to explore this further.

The findings from the current study suggest that venue staff approach patrons of concern predominately when they exhibit significant visible overt PG behaviours. This is consistent with findings from previous research [17, 35]. The data suggests three main reasons for this, all which sit within the theme of role conflict.

Firstly, despite venue staffs' reported confidence in their ability to identify a potential problem gambler, they are particularly reluctant to overtly make what they perceive to be a moral judgement about a patron. This includes staffs' reservations about making incorrect assumptions about a patron's ability to support their gambling, irrespective of whether they are based on a set of observable indicators. It also includes staffs' fears of a negative response such as anger.

Secondly, the conflict staff experience between their dual roles of facilitating the use of gaming machines in the context of a commercial business and their obligations to ensure patrons do not gamble excessively, create a perceived dilemma. This is particularly difficult in situations where staff feel unsupported by upper management. This dilemma results in staff directly engaging with patrons of concern, primarily only when they become visibly distressed or disruptive. In spite of continuing improvements in venue staffs' confidence in identifying problem gamblers, an aversion by staff to target or single out a patron and share their concern (e.g. by providing information and/or referral to treatment) appears to be an important barrier to the dissemination of responsible gambling and treatment service information to problem gamblers.

Thirdly, venue staff appear to become desensitised to the extent of patron spending and prevalence of PG in venues. Again, this results in them identifying and responding to patrons of concern chiefly only when they display significant, clear and overt PG indicators.

Role conflict experienced by venue staff was a key theme in the current data and has been described in previous research as a source of stress among staff [9]. The current data suggests that not only is role conflict a source of stress for venue staff, it also affects their willingness to directly engage with problem gamblers about their gambling. Furthermore, the findings in the current study that problem gamblers also experience the role conflict described by venue staff and that this perceived hypocrisy inhibits their receptiveness of staffs' interactions with them around their level of gambling, are new and to our knowledge have not been previously reported. Role conflict as described in this study, both for venue staff and problem gamblers, appears to have an important influence on effective engagement between the two parties concerning the provision of responsible gambling information and referral to gambling help services.

Overall, problem gamblers found the gaming room to be an unsuitable location to engage with help messaging due to their state of mind whilst gambling (e.g. 'in the zone'). Discrete areas close to, but not within, the gaming room were seen to be appropriate for the display of responsible gambling messaging and help materials. These findings suggest that it could be helpful if gamblers could access this information privately and in a context that supports self-reflection and/or personal engagement with the material for example bathroom doors, the gaming room foyer and designated smoking areas of gambling venues.

Gambling venue staff were confused and internally conflicted with respect to their responsible gambling obligations, limiting the quality and frequency of interactions with potential problem gamblers. At the same time, problem gamblers demonstrated limited awareness of the responsible gambling training gaming venue staff undertake as part of their role, which in turn contributed to their reluctance in engaging with staff around help-seeking as they did not perceive gaming venue staff to be potential sources of help. To overcome these inhibitors, venues could consider training for gaming venue staff that encourages a greater focus on the provision of responsible gambling information to all gamblers, rather than solely engaging with identified patrons of concern. Providing such information to all gamblers may help to eliminate the current perception that staff are required to make moral judgements about a patron's level of risk to harm, which has been associated with staff reluctance to approach patrons and refer to gambling help services, whereas provision of harm reduction material as a matter of course creates an environment conducive to the non-judgemental and open exchange of responsible gambling education and support. The outcome of adopting such an approach across all gambling venues is that all patrons will come to expect a dialogue around responsible gambling practice and available support services at some point. The caveat here, of course, is that the present findings indicate gamblers do not view venues as potential sources of help and perceive venue-based harm reduction initiatives to be insincere.

The findings from this study have a number of limitations which should be considered. The samples are not representative in any way of venue staff, problem gamblers or counsellors and so cannot reveal anything about the prevalence of such experiences. Furthermore, the samples are all Australian and the views expressed may not represent those from other jurisdictions. All problem

gamblers in this study had accessed treatment at some point, and therefore, their views may be different from non-treatment-seeking problem gamblers or gamblers with less severe problems. The views of non-problem gamblers and non-help-seeking problem gamblers could be explored in further research.

Conclusion

In summary, harm reduction materials in gambling venues could include personalised local help service information rather than a generic national help line, particularly for culturally diverse populations. Special attention should be paid to developing effective harm reduction and engagement strategies for Aboriginal gamblers, who are exceedingly reluctant to seek help. That being said, problem gamblers do not view the gambling venue as a place to access help-seeking information, in part due to the business versus care paradox and also because they are unaware of staffs' harm reduction training and obligations. The results from this study indicate that the involvement of venue staff in the help-seeking process is complex, stressful, conflicted and often ineffective for both staff and gamblers. The paradox between venue staff promoting gambling whilst discouraging excessive gambling is a conflict experienced by both gamblers and staff and appears to be particularly detrimental to effective engagement between the two. This conflict needs to be taken into account when considering harm reduction strategies in gambling venues. Moreover, the fundamental notion that gambling venues (which are driven by profits) are suitably able to implement and regulate harm reduction policies requires further exploration.

Abbreviations

IPA: Interpretive phenomenological analysis; PG: Problem gambling

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Availability of data and materials

The datasets generated and analysed for the current study are not publically available due to the nature of the study and concerns about the potential for the narratives to be identifiable, despite our efforts to preserve anonymity. However, any reasonable requests may be made to the corresponding author.

Authors' contributions

BR, DS and SO developed the research questions and methods. BR and SO collected the data. BR led the analyses. SO and DS provided feedback on preliminary results. SO, DS, SL, MB and MB reviewed the manuscript and provided critical inputs. All authors read and approved the final manuscript.

Ethics approval and consent to participate

All participants in the study provided informed consent, and the study received approval by the Southern Adelaide Clinical Human Research Ethics Committee approval reference number 402.13 – HREC/13/SAC/258. PG lived experience interviewees received AUS$40 honorarium for their participation.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Appendix 16. Qualitative study 2; published paper

Appendix 16.

Article

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"When I'm not angry I am anxious": The lived experiences of individuals in a relationship with a non-help-seeking problem gambler—A hermeneutic phenomenological study

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Abstract

Although the negative effects of problem gambling (PG) are well-documented in respect of gamblers themselves, less research has focused on the experiences of their partners, particularly in situations where the gambler is not help-seeking. Data were drawn from 15 in-depth interviews of partners living with a non-help-seeking problem gambler. Through a hermeneutical-phenomenological analysis, nine central themes emerged: social activity, realization, role conflict, stigma, denial, health issues, disconnectedness, hypervigilance, and security. Findings indicated that living with a non-help-seeking PG partner was characterized by chronic worry, exhaustion, relationship conflict, and an overwhelming sense of isolation. Partners found it exceedingly difficult to reliably detect their partners' gambling behavior, resulting in chronic hypervigilance, and were reluctant to seek help due to stigma. There is a need for programs that provide both guidance for partners to help protect their well-being and evidence-based strategies to help motivate non-help-seeking problem gamblers to acknowledge their problem and seek help.

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Introduction

Although the negative effects of problem gambling (PG) are well-documented in respect of gamblers themselves (Dowling et al., 2014; McCormack & Griffiths, 2011; Shannon et al., 2017), much less research has focused on the experiences of their families and close associates. Studies have estimated 4–10 concerned significant others (CSOs) experience the psychological and financial burdens attributed to an individual's gambling problem (Goodwin et al., 2017; Productivity Commission, 2010), most of whom are family members. The limited research in this area has identified three main groups of impacted significant others: partners, children, and parents (Kourgiantakis et al., 2013; Riley et al., 2018).

Partners of problem gamblers

Partners are especially impacted and report significantly higher emotional distress if they are living with the gambler (Makarchuk et al., 2002; Orford et al., 2017). Psychological symptoms of individuals living with a partner with a gambling problem, for instance, have been found to be comparable to those of psychiatric inpatients (Makarchuk et al., 2002). For example, a common experience reported by partners of individuals with gambling problems is a chronic state of anxiety attributed to the ongoing concern as to when the next gambling incident might occur (Holdsworth et al., 2013; Krishnan & Orford, 2002) and fear relating to dealings with creditors (Holdsworth et al., 2013; Mathews & Volberg, 2013). Furthermore, such individuals report higher rates of smoking, risky alcohol consumption, and other drug use (Salonen et al., 2015; Svensson et al., 2013), and experience a myriad of physical health concerns which they attribute directly to their partners' gambling problem (Chan et al., 2016; Salonen et al., 2016; Wenzel et al., 2008), such as headaches, irritable bowel issues, backaches, and hypertension (Lorenz & Yaffee, 1988, 1989; Patford, 2007). Interpersonal conflict is also commonly reported among individuals living with a PG partner (Crisp et al., 2001), and intimate partner violence is a major concern, particularly among female partners (Landon et al., 2018; Suomi et al., 2013). Further, distress for partners has been reported to be significantly and positively related to relationship distress (Hodgins, Shead, & Makarchuk, 2007). Furthermore, there is some evidence of a discrepancy between gamblers' and their family's perspectives regarding the impact of the problem, with gamblers tending to underestimate the negative effects of the problem on the well-being of their partners (Ferland et al., 2008) and children (Wurtzburg & Tan, 2011).

Treatment refusal and denial

Studies of help-seeking among individuals with gambling problems consistently report very few (less than 10%) of PGs seek formal help (Braun et al., 2014; Cunningham,

2005; Suurvali et al., 2008). PG and its consequences can remain hidden within families, usually over extended periods of time, and help-seeking is often a last resort after significant adverse events or crises such as family breakdown, loss of employment, legal issues, or deterioration of mental health (Evans & Delfabbro, 2005; Productivity Commission, 2010). In view of this, it is conceivable that the vast majority of individuals living with a PG partner are living in a situation where the gambler is not seeking help, resistant to help-seeking and in denial of their problem, and/or unaware of the extent of the problem and its impact on their partner. With this in mind, it is notable that much of the research concerning families of PGs have been conducted with clinical populations; that is, in situations where the gambler is receiving help. While insights gained from such research are useful and provide some understanding of the negative effects of living with a PG partner, we cannot assume that the experiences of partners living in situations in which the gambler is actively seeking help are the same as those in situations where the gambler is not receiving help or is in denial of the problem.

In the absence of such research concerning partners of PGs, we can look to the substance use disorders literature, where the negative impact of problematic substance use on families is well-documented (Rotunda & Doman, 2001). Similarly, help-seeking for substance-related addictions, such as alcohol, is exceedingly low (Korcha et al., 2013), with denial reported as the primary reason individuals with alcohol and or opiate problems refuse treatment (Gastala, 2017; Pickard, 2016). Despite this, the concept of denial appears to have received limited empirical attention in the substance addiction literature (Pickard, 2016), particularly concerning its impact on partners. Indeed, we were unable to locate any studies that have directly investigated the experience of individuals impacted by an unadmitted or non-help-seeking problematic substance-using partner. The issue of denial, however, has been reported within the broader context of families impacted by problematic substance use. For example, children of substance misusing parents are particularly affected by denial, as they find it almost impossible to ignore the presence of the problem, and are conflicted about keeping it a secret from those outside the family (Kroll, 2004). Furthermore, such secrecy and denial can hamper children's capacity to trust their own perceptions (Kroll, 2004). Strained communication, including continual arguing or withdrawal, is a common impact of problematic substance use on interpersonal relationships (Wilson et al., 2019). Moreover, where denial is addressed and couples are able to discuss concerns about the substance use openly together, communication is improved (Wilson et al., 2019).

Individuals with alcohol problems that do seek help frequently report receiving pressure from a variety of formal and informal sources (Korcha, et al., 2013). Likewise, there is some evidence PGs who have sought help report pressure from family as an important motivator for their help-seeking (Côté et al., 2019; Pulford et al., 2009). Families, therefore, are thought to have a significant influence on PGs' acknowledgment of their problem and their decision to seek help (Clarke et al., 2007). Nevertheless, research directly focusing on families in situations where the gambler is resistant to seeking help and/or does not acknowledge the problem appears to have been completely overlooked.

Families may be able to influence help-seeking

The idea that families, or CSOs, may provide an opportunity to help motivate non-help-seeking individuals with addictions to seek help is not new. Cognitive-behavioral interventions involving CSOs have been researched in the area of substance addiction since the mid-1980s. First developed by Sisson and Azrin (1986) for alcohol problems, the community reinforcement approach (CRA), for instance, educates substance users and their CSOs to manipulate environmental contingencies that encourage or discourage substance use (Sisson & Azrin, 1986). The approach was further developed by Meyers and Smith (1995) for situations in which individuals absolutely refuse to engage in treatment. Whereas CRA involves both substance users and their CSOs, community reinforcement and family training (CRAFT) is a unilateral intervention that teaches CSOs strategies aimed at reducing positive reinforcement for substance use while rewarding sobriety (Meyers et al., 2005). The distinction between CRA and CRAFT is that the latter does not require the addicted individual to be involved or even to be aware of the intervention. CRAFT methods have generally been shown to be effective in helping CSOs motivate their non-help-seeking or treatment-refusing alcohol, cocaine, or opioid-dependent family member into treatment (Abbott, 2009; Roozen et al., 2004). A similar yet briefer unilateral approach for partners of alcohol-dependent individuals was developed by Barber and Crisp (1995) and similarly has been shown to be effective at motivating treatment-refusing dependent individuals into treatment (Barber & Gilbertson, 1996, 1998).

There have been four attempts at adapting the CRAFT model to assist CSOs of PGs to influence treatment-refusing gamblers (Hodgins, Toneatto, et al., 2007; Magnusson et al., 2019; Makarchuk et al., 2002; Nayoski & Hodgins, 2016). Though there was some limited evidence that the well-being of CSOs improved, none of the interventions thus far have been successful in motivating the gambler into treatment. One possible shortcoming of the CRAFT research with PG CSOs to date is that we know almost nothing about the lives of individuals living with treatment-refusing PGs. CRAFT models were originally developed for use in situations involving substance dependence. Indeed, there is some evidence that the private worlds of CSOs of PGs are uniquely different from those of CSOs of alcohol-dependent individuals. For instance, partners of PGs have reported that detecting gambling behavior was not as easy as detecting drinking, which added to their distress (Heineman, 1987). Further, Makarchuk et al. (2002) reported that difficulty in identifying precisely when gambling has occurred was the biggest challenge to modifying the CRAFT materials for use with PGs. If CSOs of problem gamblers are unable to reliably detect gambling behavior, then CRAFT interventions would prove challenging to apply effectively in this context, a point similarly raised by Magnusson et al. (2019). The reviewed literature highlights the pervasive impact of PG on partners, and the potential, albeit early indications, that partners may be able to lessen denial among unadmitters and encourage help-seeking. This highlights the need to better equip families of PGs, to both protect their own well-being and encourage their loved ones to seek treatment (Hing et al., 2012).

The present study

In order to consider how individuals can effectively respond to their treatment-refusing PG partner, understanding the private often hidden worlds of individuals living with a PG partner in the context of denial or treatment refusal is both a logical and epistemologically essential next step. There is a dearth of information concerning the experiences of partners of individuals with a gambling problem in the context of treatment refusal or denial of the problem. Indeed, a recent systematic review reported that no study to date has specifically examined the impact of PG with partners of non-help-seeking problem gamblers (Riley et al., 2018). In light of this gap in the literature, the aim of this research is to describe the lived experiences of partners living with a problem gambler who either refuses to seek help despite acknowledging that they have a problem or refuses to seek help because they are in denial of their problem.

Method

The study received ethics approval by the Southern Adelaide Clinical Human Research Ethics Committee (No. 402.13).

Theoretical and analytic approach

We used an interpretive phenomenological analysis (IPA) method, as described by Smith and Osbourne (2015), utilizing a Heideggerian philosophical perspective (Heidegger, 1962). Heidegger's philosophy has paved the way for the development of interpretive phenomenological research methods to examine and understand the human lived experience, and the science of interpretation of written text (Horrigan-Kelly et al., 2016). For Heidegger, an individual cannot deliberately detach their consciousness from the world and provide an empirical account of the meaning of phenomena. Rejecting the idea of a transcendental consciousness, Heidegger argued the subject is never separated from the empirical world (Lewis, 2010); rather, he described this as "being-in-the-world" and referred to this specific type of "being-ness" as "Dasein."

Hermeneutics is a term used to describe the process of interpretation, typically the interpretation of texts (Sherma & Sharma, 2008). In other words, an individual's account of their experience is interpretive rather than a pure and objective description. Interpretive hermeneutics facilitates an understanding of phenomena by providing a method of gaining access to Dasein (Horrigan-Kelly et al., 2016). IPA is concerned with examining how individuals make sense of their experiences (Pietkiewicz & Smith, 2014). To understand the meaning of an experience to an individual, the researcher must engage and interpret the individual as they themselves interpret and make sense of their own experience. This two-staged analytical process of studying experience is described by Smith and Osborne (2015) as a double hermeneutic, which can be useful for discovering meaning which may be hidden due to the phenomena's mode of appearing (Smith & Shinebourne, 2012). Further, IPA is especially valuable when little is known about the phenomenon being studied (De Witt & Ploeg, 2006), and for exploring private worlds and sensitive interpersonal issues (such as the experiences of CSOs of non-help-

seeking PGs), respecting and telling that experience from the person's perspective. Therefore, the theoretical framework for this research is hermeneutics underpinned by a subjectivist paradigm.

Sampling and recruitment

Purposeful sampling was used to select information-rich cases related to the phenomenon of interest (Palinkas et al., 2015). We chose this sampling method considering we wanted to gain a deeper understanding of the phenomena of interest rather than to generalize findings to a wider population (Palinkas et al., 2015). Participants were recruited through flyers placed in public access buildings such as community centers, shopping centers, and public hospitals. The flyers stated that the researchers were seeking individuals living with a partner with a gambling problem who was not actively seeking or receiving help. Once potential participants made contact by a telephone call to the researcher (BR), a telephone screening interview was conducted by (BR) to determine suitability for the study. If the participant met the eligibility criteria (see below) they were invited to attend a face-to-face interview.

Procedure and data collection

To capture the lived experience of living with a partner with a gambling problem who is resistant to seeking help or does not acknowledge the problem, individual face-to-face in-depth interviews were used. The interview schedule was informed by a literature review and final questions discussed and developed by the research team. Interviews were semi-structured and open-ended and covered three broad areas: participants' experience living with a problem gambler and how it has affected them and their relationship; how the participants have responded when their partner gambled; participants' experience approaching their partner about PG. When investigating the nature of lived experience, qualitative interviews are a useful method of gathering experiential narrative material to enable a rich and deep understanding of the phenomenon (van Manen, 1990).

Participants were South Australian men and women who were living with an intimate partner of the same or opposite sex where the partner had a gambling problem and was not currently seeking help due to treatment refusal or denial of the problem. Inclusion criteria were that the partner of the gambler was 18 years of age or older and that the gambler had a current gambling problem. The individual with the gambling problem was not required to have been formally diagnosed with a gambling disorder. It was sufficient that the affected CSO reported that their partner had a gambling problem. CSOs have been found to be able to report PG behavior in a reliable and valid manner (Hodgins & Makarchuk, 2003). An initial screening interview was conducted by telephone to assess the following two exclusion criteria. First, risk of abuse or violence to the prospective participant as a result of their participation becoming known to the problem gambler. Prospective participants were asked a series of questions concerning characteristics of their relationship to the problem gambler including any history of domestic violence. Second, participants were excluded if the prospective participant also had a gambling

problem, which was assessed via a discussion with the prospective participant about their own involvement with gambling.

Fifteen participants were included in the study (12 females and 3 males) with a mean age of 50 years (*SD*, 11.84; range 28–69). The mean length of the relationship with the gambling partner was 9.81 years (*SD*, 7.61; range 1–30). Nine couples had dependent children. Forms of gambling that the PG partners engaged in comprised land-based electronic gaming machines ($n = 8$), horse racing ($n = 4$), horse racing and land-based electronic gaming machines ($n = 1$), land-based electronic gaming machines, keno and on-line sports betting ($n = 1$), and online electronic gaming machines/slots ($n = 1$). Of note, three potential participants (all female) did not follow through with arranging an interview after making initial contact, reporting that they were concerned their gambling partner might learn of their involvement which would lead to conflict. All the participants who were interviewed reported that their gambling partner was unaware of their involvement in the study.

All interviews were conducted by the first author (B.R.). The interviews were carried out at locations convenient for the participants and included a university office and a community-based health center. Interviews were recorded on a digital audio-recording device and professionally transcribed. All participants provided signed consent and received a $40 valued honorarium gift card for their involvement in the study.

Data analysis and verification procedures: Revealing the phenomenon

Transcriptions were uploaded into NVivo qualitative data analysis software (QSR International Pty Ltd. Version 11, 2015). The analytical guidelines for IPA as recommended by Pietkiewicz and Smith (2014) were applied. First, audio recordings were listened to and the verbatim transcriptions read multiple times by the first author, focusing on what the text was saying (Ricoeur, 1976). Initial interpretive exploratory notes were made and transformed into 30 potential emergent themes and 23 subthemes. The researchers then met to discuss the interpretive notes and emergent themes. Next, all transcripts were phenomenologically coded and phenomenological clusters were developed. As the text was read and re-read, individual parts of the text were interpreted in the context of the whole data set. Continual movement between the parts and the whole (the hermeneutic cycle) led to a deeper understanding of the text and allowed us to move from an understanding of what the text was saying to an understanding of what it talked about. The meaning of a text is the interaction between the written narrative and the researchers' interpretation. As Ricoeur (1976) observes, "the sense of a text is not behind the text, but in front of it. It is not something hidden, but something disclosed" (p. 87). The researchers met several times throughout this analytic process to discuss interpretations and developing themes. B.R., S.L., and B.C. undertook regular robust discussions during the analysis period to reach concordance. For instance, early in the analytic process, "lack of intimacy" emerged as a potential theme. Through further analysis and discussion, it was agreed that "disconnectedness" more accurately captured the essence of participants' experiences. The final three transcripts did not yield any novel code dimensions, therefore, it was deemed we had reached meaning saturation (Hennink et al., 2017). During this phase, it became apparent that the notion of time was

Table 1. Dominant themes and exemplificative verbatim quotes arranged according to the three time frames.

Time frame	Dominant themes	Exemplificative verbatim quotes
Past		
	Social activity	*And then we would make it a day, we'd go to the races; we'd have lunch there or stay behind for dinner. It was an outing, it was good and it was fun.*
	Realization	*It happened a couple of times and then my frustration hit the limit so I discussed it with him and he confessed.*
Present		
	Role conflict	*I feel like he's my child because I feel like I'm constantly monitoring him like a teenager, what they're up to and are they telling lies, like I'm his mum. And he's 11 years older than me so I'd expect a little bit more-that's the point of going out with someone that's a decade older than you.*
	Stigma	*Because I'm embarrassed about sticking around.*
	Denial	*The anger's about the lying and I think the anger is also his inability to admit that there's a problem, like to me.*
	Disconnectedness	*We're housemates. Just living together but not-not even communicating about-housemates at least communicate about bills.*
Future		
	Hypervigilance	*How am I going to afford the power bill, the gas bill, and what are we going to do when the rego comes in?*
	Security	*As we get older our needs for finances are going to increase.*

an important perspective across the data set and clearly influenced participants' interpretations of their lived experience. The existential of time is a central concept within Heideggers' phenomenology (Heidegger, 1962). Heidegger argued that the human lived experience must be interpreted in the context of the temporal frames; past, present, and future, and that removing a story from such context may remove its meaning and therefore our understanding of the phenomenon under study (Smythe et al., 2008). Subsequently, we decided to appraise the phenomenological themes according to the three different time frames: past, present, and future. This careful analytical process led to a final list of nine interpretive themes across the three time perspectives: two themes each for past and future and five for the present. To illustrate the themes that emerged, relevant examples from the discourse are presented.

Results

Table 1 presents the final phenomenological themes within the three time frames along with supporting exemplificative quotes. The majority of data were grouped under the time frame of present, which reflects the emotional state most participants were experiencing in that the problem was current and raw. Many participants were clearly distressed and reported they had not spoken so candidly about their private situation, which largely remained hidden from friends and family. Continued gambling episodes

alongside denial of the problem and or the need for help were among the greatest source of distress for participants.

Past

Social activity. All participants could remember a time when their relationship did not involve PG. That is, none were aware of the gambling problem when they entered the relationship: Either the problem was hidden from them or it developed at a later stage. Some were aware that their partner gambled when they met, while others remembered when their partner began gambling. All participants, however, were unaware of the extent of the gambling or that it was problematic, for a considerable time. The theme social activity refers to the manner in which gambling was described in the past, before awareness of the problem. For some, it was a fun outing; for example, a day at the races or a night out at a hotel. Several participants explained that they did not experience it as gambling per se, rather, it was a social outing that involved gambling.

> It was an outing, it was good and it was fun, and in the beginning it was a place to go because you really had to dress up at night. We'd go there with probably a member of his family or something sometimes, or just him and I, we'd go for dinner.

Realization. Realization of the problem was described by every participant as they recalled the moment they became aware of their partner's problem. This was generally expressed as a time of crisis, and on reflection, a sense of shame in that felt they should have noticed the problem sooner. Anger was also a common experience, as participants described learning the extent of the problem while their partner denied or minimalized it. Verbal conflict was a common experience, with one female participant reporting having been physically assaulted by her gambling partner during a confrontation. The following two comments, each by separate female participants, illustrate the exasperation, disbelief, and frustration experienced by CSOs:

> No idea. I mean I was just devastated and I just couldn't believe it. And I confronted him and said to him "where's the money gone, what did you do with it?" He gave me some reasons about "having the new house and money. . . " but I knew damn well in the end.

> "You've got to be kidding me. $8,000, [name], where's it gone?" And I said to him, "You have got to admit that you've got a problem" and he just turned his back and walked away.

While participants made a clear distinction between their relationships prior to the disclosure of PG, the majority of conversation concerned the current impact of the problem, which was set in the time frame of the present.

Present

Role conflict. This theme contained a substantial amount of data and refers to the partners taking on additional roles in response to the gambling problem. Their "dasein" had been modified to accommodate the "being-in-the-worldness" of a relationship involving PG.

In order to manage the problem, participants had adapted to taking on numerous additional responsibilities which over time affected their relationship. It was a case of the solution becoming a problem. Participants commonly described feeling that they were taking on a parenting role by managing their partners' finances and monitoring their movements. This change in roles had a significant impact on the relationship and though they felt it necessary, most disliked treating their gambling partner like a "naughty child."

> I don't want to be treating him like a child. I don't want to be married to somebody who I have that sort of relationship with.

Female participants commonly described feeling like they were taking on a "mothering" role, for example, hiding money from their partner:

> It makes me feel like I have to like I have to mother him and to hide like I shouldn't have to hide money. But he's basically like a 2-year-old with a credit card.

Taking on an additional mothering role was frequently experienced as a burden due to the extra responsibility:

> I've had to become more of a mother figure I feel. I've had to take on this additional responsibility; I feel that I've had to do that now. I feel like I'm the responsible one in the relationship.

It became clear that the change in dynamics in the relationship was a major source of stress for participants. Additionally, there was a sense of loss in that they had lost the support of their partner who in their eyes had become a "child," at a time when their lives had been thrown into turmoil, and they found themselves managing everything.

> It's had a huge impact on our relationship down to that it's changed the whole dynamic, the whole power in our relationship has shifted I think.

The burden of extra responsibility in having to manage the consequences of the gambling problem (such as payment of debts and bills), along with managing harm reduction and minimization strategies, is illustrated by the following participant's comment:

> Yep, and manage him. So I'm managing my half. Now I'm managing your half. Now I'm managing you as well.

One participant described how they had returned the role of financial administration to their gambling partner despite knowing they would continue to gamble heavily. This participant explained that she would rather experience the effects of gambling, in return for giving her husband back his "maleness" and surrendering her role of a financial administrator.

Stigma. Participants felt they needed to keep the problem secret, as they were concerned if others learned of the problem, they would judge both the gambler and themselves for continuing to be in the relationship. Frequently, partners were conflicted between wanting to stay in the relationship, but not a relationship that involved PG.

> I guess it's a reflection on me as thinking these people think I'm an idiot... I'm not going to tell them... but it's more so about how they would treat [name] that I'm trying to protect.

Denial. Frustration regarding the gamblers' lack of acknowledgment of their problem was a common and particularly upsetting experience among participants. Relationship conflict was reported frequently and typically related to gamblers denying their problem and or gambling behavior. This affected other parts of the relationship as participants began to question their partners' honesty more broadly. As illustrated by the following participant's comment, partners voiced concern that if the gambler willingly lied about their gambling, they may also be lying about other behaviors harmful to the relationship:

> It might be a lie as well... so once he's denying about the gambling so other stuff like smoking, drinking, or spending time somewhere, it might be a lie as well.

Overall, there was a strong sense across the data set that trust had been damaged considerably and was having a damaging effect on the relationships:

> Well for me that's very difficult because the trust is shattered. I mean you don't know when he's lying and when he's not lying, it's hard to distinguish yeah, what's true, what's not true and it's well for me it has been very hard.

Exhaustion. Collectively, participants were both physically and emotionally exhausted. Clearly, the impact and lack of acknowledgment by gamblers of their gambling problem was related to numerous physical and emotional ailments. The experience of exhaustion was distinct, and while embedded in the present time frame, it also related to the past and future. For example, ruminating about their relationship prior to the problem and how much money had been lost (past), in addition to worries about the future, such as when their partner might gamble again and if there will be enough money for bills (future). This fluidity across the three time frames is evident in the following participant comment:

> My health's sliding away (cries). My face is from all the crying, it's no longer the face it was. I can't get that face back that I had before (cries).

The first part of this comment is distinctly in the present "my health's sliding away. My face is..." The next part of the comment moves to the past perspective as the participant remembers what they used to be, "no longer the face it was" before switching to the future as they contemplate not being able to be that person again, "I can't get that face back" and then back to the past, "that I had before."

Disconnectedness. The theme disconnectedness refers to the experience of couples living parallel lives. Related to role conflict, participants described, quite literally at times, feeling as if they were living separate parallel lives under the same roof. This theme also relates to the sense of exhaustion and isolation experienced by participants. A frequently reported consequence of disconnectedness was a lack of emotional and physical intimacy, which largely related to the gambling problem. This sense of disconnectedness was described by both males and females. While discussing how gambling had changed their relationship, one male participant noted that they were now more separate than ever:

> Well she watches her [foreign language] TV and I hang with the boy and we watch men's stuff. We're basically in a separate lounge to where she is in the kitchen area so we can basically see each other from where we're sitting but me and him watch footy, cricket, men's stuff and she's got her [foreign language] TV.

Disconnectedness was also illustrated by partners describing the gambler as being constantly distracted or preoccupied with gambling. In the following comment, the participant describes her gambling partner's preoccupation with horse racing:

> Well just things like having to listen to races. We might be in a conversation and there's a race on and I feel he's not listening to me. There's always races. Even at 10 o'clock at night, we'll be in bed together and he'll put on the headphones for races and I find races really irritating to listen to.

The disconnectedness theme is further evidenced by the following female participant's comment, where she strikingly describes her experience of living with "another person" rather than her partner.

> Well, honestly it's just been like in the last six, eight years or something, it's just been like living with another person not as a partner.

While distress and worry were common experiences contained in the present time frame, however, there were clearly distinct shared anxieties concerning the future.

Future

The time frame of future was predominantly concerned with the near future, such as bills that were due and worries about being contacted by debt collectors. Additionally, there was a sense of worry about the longer term, for example, financial security and the relationship in the longer term.

Hypervigilance. While rumination relates to the past, anxiety concerns future worries and feared events that have not happened. Hypervigilance refers to near future worries. This was clearly related to the poor health experienced by participants. They described chronic worry which was present even when there was no detectable gambling. When there were no signs of gambling, participants were worried about when it might happen

next. One husband reported worrying every evening if his wife would come home late and then what he would cook for his children. Even on occasions when his wife did come home without gambling, the worry persisted as he worried it might happen the following evening.

> What am I going to cook for these kids if you [wife] don't come home? Do you think I'm going to sit there and look at them and leave them without food?

One participant described their experience of implementing harm minimization strategies while working extended hours to cover gambling debts and then worrying about how such lifestyle changes might affect their children:

> It's just it still is every day waking up and being like what's going happen today? How much is he going to take today? What can I do today to stop that from happening? Should I stay back at work? Should I do the rosters so that I'm working 50 hours just to cover it but then in doing that I'm taking away from my kids?

The constant presence of worry was a collective experience among participants and related to both the concern about how they were going to meet all their financial obligations and when the gambler might next gamble:

> That's the other thing; it's always sitting in the back of my mind. It's a worry, it's a constant worry, it's a constant source of anxiety for me, worrying about how we're going to get everything paid.

The following participant's comment illustrates how constant worry about when their partner might next gamble, created additional vigilance for them as they monitored the gambler's whereabouts:

> Yes, and I'm anxious all the time he might go in for gambling after work so I was checking when he would be finishing work and that sort of stuff and when will he be home.

Security. This theme refers to longer term worries such as savings, presents for children at Christmas, will the gambler ever be "cured," and the future of the relationship. Though hypervigilance is related to this theme, there were two distinct futures in the narratives: near and distant. A number of female participants did not want to get married until the gambling problem was addressed, while at the same time worried that they might miss their opportunity to have children if they waited for too long.

> I think to myself am I wasting my time because I'm at that age where babies are cut-off in a few years, I think to myself gosh. So that's where a lot of the stress and anxiety comes from as well.

Several participants spoke of future consequences they pledged to their gambling partner should they gamble again. They then described worry about further gambling as

they did not want to break up the family. Thus, in an attempt to put a stop to the gambling by providing an ultimatum, they increased their hypervigilance.

> If you [the gambling partner] were ever to do this to me and your family again I will leave . . . I gave it to her and said if you ever do anything like this again, that is the consequence.

Others experienced a reluctance to make plans for the future through fear such plans might be crushed by the gambling problem. Avoidance of making future plans with their partner was, therefore, a protective strategy.

> I'm reluctant to make any plans for the future with him and the lies are just so destructive, they really are. Like I said, because sometimes I can tell when he's lying but other times I just don't know.

Discussion

The results from this study provide a rich insight into the lives of individuals living with a partner who has a gambling problem and who is resistant to seeking help or is in denial of their problem (referred to here as unadmitted). To the best of our knowledge, this is a cohort that has not previously been directly researched. In spite of the fact that the majority of individuals with gambling problems do not seek help, partners of non-help-seeking PGs have received almost no attention. Moreover, research involving unadmitted PGs is virtually nonexistent since they would be exceptionally difficult to recruit for research purposes. The results of this study, therefore, provide a unique insight into the private worlds of unadmitted PG. Through the analyses of 15 in-depth interviews based on an interpretive phenomenological method (Pietkiewicz & Smith, 2014), 9 dominant themes were revealed. The nine themes showed that participants living with a non-help-seeking PG partner were characterized by chronic worry, exhaustion, relationship conflict, and an overwhelming sense of isolation.

In terms of discovering the gambling problem, all participants described this as a distinctly distressing moment. Revelation went hand in hand with an initial confrontation which was in most cases met with denial and led to conflict. From the moment the problem was exposed, participants experienced chronic hypervigilance as they worried about future gambling episodes.

We interpreted participant narratives through Heidegger's phenomenological perspective of time. In doing so, we considered "what is it like for participants to be *in* time?" According to Heidegger, time is meaningful only for a being that lives with an awareness of its own finality (Alweiss, 2002). This was apparent in the narratives, particularly as participants considered their longer term future; for example, concern about missing their opportunity to have children. Participants were distinctly aware that the world they were presently in was different than the one they inhabited prior to the revelation of PG.

The health issues among participants described in this study are consistent with previous literature (Wenzel, et al., 2008). The lived experience of physical and emotional

stress resulting from living with a non-help-seeking PG partner was one of complete exhaustion. What the narratives revealed was that, in terms of coping, partners had taken on additional roles to manage the gambling problem and moderate their emotional distress. Paradoxically, the additional responsibilities only added to their distress at a time when their partners had, in their view, regressed to behaving like a child or teenager, and were thus unavailable for support. This ultimately resulted in an experience of worry, exhaustion, and isolation.

The effect of role conflict on interpersonal relationships was a dominant theme. Such conflict, was in part, related to gendered roles stemming from societal stereotypes. Social role theory pertains that sex differences and similarities in behavior reflect gender role beliefs that correspondingly represent people's perceptions of men's and women's social roles in the society in which they live (Eagly & Wood, 2011). We found, for example, that female partners were particularly conflicted about assuming the responsibility of the household finances, and in some instances, even distributing their male partner's "spending" money, thereby, altering the power relationship in the dyad. Previous research has identified, where females acquire increased power in a heterosexual relationship, they face greater difficulty in resolving conflict than male-dominated dyads, particularly among non-Western couples, who face stricter patriarchal norms (Dunbar, 2015). This issue requires further research, especially among ethnic minority groups. Role conflict was also evident among male participants, though for different reasons. For instance, one man described frustration that he had to prepare the family meals due to his wife's absences while she gambled. The data did suggest some differences in how men and women experienced living with a non-help-seeking problem gambler; however, it should be noted that we had just three male participants. This could be explored with further research, and social role theory (Eagly & Wood, 2011) may provide a useful theoretical framework to do so.

Participant narratives revealed considerable reluctance to turn to friends or family for support due to issues around stigma. The nature of stigma described by participants related to their concern about both the gambler being negatively evaluated and themselves being judged for providing support to the gambler and remaining in the relationship. First described by Goffman (1963), the "courtesy stigma" refers to the stigma experienced by individuals who associate with stigmatized groups or persons. Though the role of stigma experienced by PGs themselves has been examined previously (Hing et al. 2014, 2016), courtesy stigma has only very recently been applied to PG (Matthew et al., 2019). Early indications suggest it could be useful in understanding the impacts of PG on CSOs and help to guide support services. Findings from the present study support this view and highlight this as a potentially useful avenue for future inquiry. There was also some indication that partners were reluctant to actively encourage the gambler to acknowledge their problem and seek help due to fears of further harming the relationship. The theory of vicarious help-seeking concerns the intent to help others who appear in need of help, but who are not actively seeking help, and argues that the fear of intervening with a friend (in violence prevention contexts) tends to be proportional to how much they care about damaging the relationship (Williams et al., 2018). This may offer a useful framework from which to investigate vicarious help-seeking, in the context of unadmitted PGs.

In the current study, the theme hypervigilance was for the most part related to partners being unable to determine if gambling had occurred. Though there were clearly observable signs, participants were able to describe if their partner had gambled, such as a substantial win or loss, importantly, an absence of observable signs did not necessarily mean an absence of gambling. Hence, partners experienced ongoing worry about recent losses, increasing debts, and unpaid bills. This was a common experience across the sample. Thus, unilateral interventions designed for partners or families, that rely on the ability to respond to gambling behavior reliably and consistently (such as CRAFT; Hodgins, Toneatto, et al., 2007; Magnusson et al., 2019; Makarchuk et al., 2002; Nayoski & Hodgins, 2016), would be particularly challenging. That said, a recent study involving couples, in which one member was a problem gambler, provides some early evidence that partners living with a problem gambler can, in fact, influence the gamblers' behavior (Côté et al., 2019). Further research in this area is warranted.

Several published clinical treatment guides for PG advice that stimulus control strategies should be employed, such as asking the gambler to restrict their access to money by arranging for a family member to manage their financial affairs (e.g., Grant, 2011; Ladouceur & Lachance, 2006; Raylu & Oei, 2010). The aforementioned advice highlights the need for individuals to protect themselves and their well-being from the harms of living with a problem gambler. That said, in light of the findings of the current study, it is important to recognize that such strategies may have their own negative consequences that need to be acknowledged and addressed.

Strengths limitations and directions for future research

The strengths of this study include its qualitative exploratory nature. The chosen methodology provided an opportunity to gather rich information, allowing us to reveal a deep understanding of a typically private and hidden world which has received very little empirical attention. A further strength is that the sample comprised partners of non-help-seeking or unadmitted problem gamblers, which, to our knowledge, are a cohort that has not previously been directly investigated. In addition, the gambling partners engaged in a range of gambling activities including horse and sports betting, keno, and land-based and online slots. This provided an insight into the private worlds of individuals impacted by a PG partner where a variety of gambling types was involved. That said, the heterogeneity concerning forms of gambling may also serve as a limitation. For example, observable gambling behaviors related to internet gambling on a portable device such as a smartphone may be less noticeable for partners than gambling which involves attending a land-based venue for a period of time away from home. To understand a more complete portrait of the impacts of a specific form of gambling, a relevant homogenous sample may be more useful. A further limitation of this study is that the sample was composed entirely of white Anglo-Saxon or European Australians. Therefore, our findings do not inform us of the experiences of individuals from culturally diverse minority groups. Further research that extends this work across culturally and linguistically diverse groups would be useful. In addition to the aforementioned limitations, one which raises interesting questions to be taken up in future research is the difficulty we had recruiting male participants. Although we made considerable effort to advertise the study in multiple

locations across a metropolitan city, only three males (who all participated) responded to the study invitation. This may, however, be reflective of prevalence studies which report twice as many males than females experience gambling problems (Williams et al., 2012), suggesting that more female partners may be impacted. Nevertheless, future research could target male partners of unadmitted PGs. Notwithstanding these limitations, this study provides a first step in understanding the experiences of individuals living with a non-help-seeking problem gambler.

In conclusion, this research indicates that partners living with a non-help-seeking problem gambler experience a myriad of emotional and physical health issues. Further, they are reluctant to seek help either formally or via friends and family due to both stigma concerning the gambling partner and themselves through stigma by association. Additionally, they find it exceedingly difficult to reliably detect their partners' gambling behavior and an absence of gambling behavior, which in turn results in chronic hyper-vigilance. There is an urgent need for support programs that provide not only guidance for partners to help cope with the gambling problem and protect their own well-being but also evidence-based strategies that help motivate the treatment refusing or unadmitted problem gambler to acknowledge their problem and seek help. The development of such strategies may provide opportunities for health and community services to promote programs for CSOs that include engagement of non-help-seeking PGs as a clear aim. Though it is not without unique challenges, recent studies indicate early evidence that partners may be able to influence their gambling spouses' gambling behavior and decision to seek help. Further research is required to progress this line of inquiry, and we hope the current research helps to guide further development in this area.

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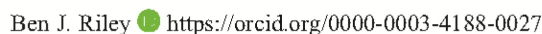
Ben J. Riley  https://orcid.org/0000-0003-4188-0027

Open research statement

This research was not pre-registered. The data used in the research cannot be publicly shared due to the nature of the study and concerns about the potential for the narratives to be identifiable, despite our efforts to preserve anonymity. However, any reasonable requests may be made to the corresponding author at ben.riley@sa.gov.au.

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Appendix 17. Poster presented at International Gambling Conference 2018 Auckland New Zealand

BUSINESS V CARE IN GAMBLING VENUES

UNDERSTANDING THE PARADOX

BEN RILEY, SIMONE ORLOWSKI, DAVID SMITH, MALCOLM BATTERSBY, MICHAEL BAIGENT & SHARON LAWN FLINDERS UNIVERSITY, SOUTH AUSTRALIA

INTRODUCTION

- Australia has the highest gambling participation rate and among the largest number of electronic gaming machines per capita in the world.[1]
- 2.5% of australian adults experience problem gambling.[1]
- Help-seeking rates are low[1] and often a last resort during/after crisis.[1,2]
- Recent years, greater emphasis placed on gambling venues to identify and respond to potential problem gamblers.
- Limited research on how to best respond and facilitate treatment referral.
- Next logical next step? Understand perspectives of staff and problem gamblers.

AIMS

To explore:

- Experiences and perceptions of problem gamblers, venue staff and treatment providers on how problem gamblers experience being identified and referred for treatment by venue staff.
- How venue staff experience identifying and approaching problem gamblers.

METHODS

DESIGN 4 focus groups followed by 9 semi-structured in-depth interviews

SETTING Adelaide, Australia

PARTICIPANTS 22 problem gamblers, 10 gambling venue staff and 8 problem gambling counsellors from gambling help services (GHS)

+ Semi-structured interview guide
+ Interpretive phenomenological analyses

DISCUSSION

- Venue staff approach patrons of concern primarily when they exhibit overt problem gambling behaviours, consistent with previous research.[3,4]
- The main reasons for staff delaying intervention sit within the theme of role conflict.
- Role conflict was a key theme and has been described in previous research as a source of stress among venue staff.[5]
- Role conflict affects staffs' willingness to engage with potential problem gamblers about their gambling.
- Perceived hypocrisy experienced by both venue staff and problem gamblers, impedes effective provision of responsible gambling information and referral to GHS.

CONCLUSIONS

- Role conflict experienced by gambling venue staff and patrons alike, inhibits effective engagement and referral.
- Reducing the need for gambling venue staff to make a perceived moral judgement about the gambling behaviours of specific patrons, may improve the provision and reception of responsible gambling information.
- Provision of general education and information to all gamblers, rather than solely engaging with identified patrons of concern, may reduce role conflict and promote help-seeking.

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RESULTS

Six themes emerged through the focus groups. The in-depth interviews supported all themes and led to an additional seventh theme.

THEME 1
ROLE CONFLICT

Perceived divergence of venue staffs' hospitality duties and responsible gambling obligations, a discrepancy experienced from many perspectives across all groups.

THEME 2
PERSONAL CONNECTION

Importance of rapport between: problem gamblers and gaming venue staff; gaming venue staff and GHS staff; problem gamblers and GHS staff.

THEME 3
LACK OF AWARENESS

Venue staff and gamblers described a lack of awareness of available problem gambling supports.

THEME 4
DISCRETION AND PRIVACY

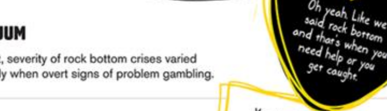
This theme refers to the significant role perceived public stigma played in both inhibiting and fostering help-seeking.

THEME 5
ORGANISATIONAL INCONSISTENCIES

Frustrations experienced across all focus groups that related to procedural inconsistencies, such as the inability of venues to share information about patrons of concern.

THEME 6
ROCK BOTTOM AS A CONTINUUM

Gamblers sought help as a last resort, severity of rock bottom crises varied greatly, and venue staff intervened only when overt signs of problem gambling.



THEME 7
RECOVERY A STRAIGHT FORWARD PROCESS?

Gamblers were reluctant to access help again following a relapse of their gambling

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