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What makes people with gambling disorder undergo treatment? Patient and professional perspectives

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Abstract

Aims: The aim of the article is to identify factors which bring people with gambling disorder to undergo treatment. We are interested in exploring motives that trigger change; identifying factors determining choice of facility; recognising barriers and facilitators appearing during treatment. **Design:** Semi-structured interviews were conducted in Poland with people with gambling disorder, as well as with social workers, therapists, General Practitioners (GP) and psychiatrists. Purposive sampling was applied in selecting respondents. In total, 90 interviews were completed. **Results:** Internal and external motives that trigger change were identified. Among the internal motives were individuals' own reflections often combined with a sense of guilt, and among the external motives, pressure from significant others, financial problems, law problems and somatic and mental problems. The choice of facility was made by those suffering from gambling disorder or by close family members. Factors which influenced the choice of clinics were availability (distance to the facility, sessions schedule), quality of infrastructure, assured anonymity, opinions on provided assistance, the renown of such a facility, apparent experience in treatment of gambling disorder, and the context behind the problems experienced. Individual (related to emotions and convictions,) and structural barriers (related to the treatment offer, infrastructure, personnel, and

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therapy programme) were identified along with the facilitators in the access to treatment. **Conclusions:** The identification of circumstances and determinants may contribute to improvements in the availability and quality of assistance provided, which could result in an increase in the percentage of patients undertaking treatment. There is a need for education aimed at increasing awareness of the problem and the possibilities of assistance as GPs and social workers very rarely recognise gambling disorder among their clients.

Keywords
barriers, determinants, facilitators, gambling disorder, motives, treatment

The last few decades have witnessed changes on the global gambling market, and gambling disorders have increasingly become a public health concern (Lorains, Cowlishaw, & Thomas, 2011). The availability of gambling has increased as a result of new types of games, especially with the use of the Internet and mobile electronic devices (Olason, Hayer, Brosowski, & Meyer, 2015; St-Pierre, Walker, Derevensky, & Gupta, 2014).

Several international studies have shown that only a few of those diagnosed with gambling disorder have sought professional treatment or attended Gamblers Anonymous (GA) meetings (Cunningham, 2005; Petry, 2005). In the United States, between 7.1% and 9.9% of people with gambling disorder have sought help for their disorder (Slutske, 2006; Volberg, Nysse-Carris, & Gerstein, 2006). In Ontario, Canada, 10% of problem gamblers and 29% of pathological gamblers started treatment or attended GA meetings (Suurvali, Hodgins, Toneatto, & Cunningham, 2008). Similar results have been found in countries from the Pacific region. In Australia, 23% of people diagnosed with "severe" problems and 7% with "less severe" problems were actively seeking help for their gambling concerns (Productivity Commission, 2010). In New Zealand, 10–15% of problem gamblers were seeking formal help (Ministry of Health, 2007).

Those with gambling disorder seeking treatment usually did so after a crisis triggered by an often-severe occurrence with negative consequences. The motivation to seek treatment can typically be divided into internal and external factors. Internal motivation is often based on one's own conviction about the necessity of change, whereas external factors often involve pressure from the closest environment, and treatment is undertaken to achieve a reward or avoid punishment (Deci & Ryan, 1985). Studies from the field of alcohol dependence treatment show that in most cases the change involves external pressure; during the therapeutic process therapists try to convert such pressure into internal motivation in order to maintain abstinence (Miller, 2009; Prochaska, DiClemente, & Norcross, 1992). In many situations financial problems are the predominant motive for seeking treatment, although family or relationship troubles tend to be equally significant (Gainsbury, Hing, & Suhonen, 2014; Suurvali, Cordingley, Hodgins, & Cunningham, 2009; Suurvali, Hodgins, & Cunningham, 2010; Suurvali, Hodgins, Toneatto, & Cunningham, 2012a). Other motivators highlighted in the studies pertain to physical or mental health as well as emotional factors, severity of gambling-related consequences, and escalation of gambling problems (Evans & Delfabbro, 2005; Gainsbury et al., 2014; Hodgins & el-Guebaly, 2000; Pulford et al., 2009; Tavares, Martins, Zilberman, & El-Guebaly, 2002). Of lesser significance is the impact of gambling venues, legal issues, and problems at work and with living circumstances (Gainsbury et al., 2014). The literature review by Suurvali et al.

(2010) shows that many of the identified motivators are transnational such as financial problems, relationships with others, negative emotions, the evaluation and decision-making processes about quitting or cutting down on gambling, work or legal difficulties, and that these same motives are recognised in different parts of the world by people with gambling problems.

The decision of starting treatment could be postponed due to the barriers which people with gambling disorder meet. These barriers also determine the choice of facility. In the selected literature, barriers are divided into psychological and structural elements. Psychological barriers include the following: lack of awareness or acceptance that gambling may become a disorder, lack of awareness of services, disregarding the problem of gambling, believing that problems can be resolved without professional assistance, the shame and embarrassment of having such a problem, reluctance to disclose it to others, wariness and lack of understanding of treatment, a perceived lack of effectiveness of treatment, and negative previous experiences with such treatment (Dąbrowska, Moskalewicz, & Wieczorek, 2016; Evans & Delfabbro, 2005; Gainsbury et al., 2014; Pulford et al., 2009; Rockloff & Schofield, 2004; Suurvali et al., 2009; Tavares et al., 2002). Structural barriers refer to hours of treatment which do not fit in with the daily schedule, time commitments, geographical location, and information about available help services (Dąbrowska et al., 2016; Hing & Nuske, 2011; Pulford et al., 2009; Suurvali et al., 2009; Suurvali, Hodgins, Toneatto, & Cunningham, 2012b). In countries where treatment has to be paid for, costs are perceived as a barrier. In regions with culturally diversified language problems such factors also discourage addicts from seeking help (Gainsbury et al., 2014).

Some barriers have both a psychological and structural character, such as information about offers of treatment which can be perceived as a lack of knowledge about the possibilities of treatment as well as a lack of advertisement of such services (Dąbrowska et al., 2016; Suurvali et al., 2009).

It is worth mentioning that in most surveys the study sample only consists of people with gambling disorder. There is thus a lack of studies which highlight the perspective of professionals. In a study conducted by Sullivan, Arroll, Coster, Abbott, and Adams (2000), the focus is on general practitioners (GPs) with regard to their competency and apparent limited knowledge of what to do and where to refer problem gamblers for help.

Our study aims to identify factors which bring people with gambling disorder to undergo treatment, especially:

- exploring motives that trigger change,
- identifying factors determining choice of facility, and
- recognition of barriers and facilitators appearing during the treatment process.

Materials and methods

Local context of the study

Gambling in Poland is regulated by a legal act that covers, under state monopoly, particular gambling activities such as "games of chance", cash lotteries, the opening and running of Electronic Gambling Machine (EGM) arcades, and online gambling. It is possible for private entrepreneurs to run casinos, sports betting (also on the Internet), and promotional lotteries. EGMs can also be placed in casinos. Private operators are required to obtain a licence to run casinos, and a permit to run other gambling activities. Participation in gambling is allowed from the age of 18 years (Gambling Law of 19 November, 2009).

The results of a study conducted in 2014 show that every third Pole (34.2%) aged 15 years and over had gambled at least once during the 12 months before the study, and 7.1% had gambled almost every day. Symptoms of gambling disorder were diagnosed with the use of the Canadian Problem Gambling Index and

occurred in more than 5% of those aged 15 years and older. Almost 4% revealed a low level of risk, 0.7% revealed a moderate level of risk, and 0.7% had a problem with gambling. Estimations based on medical data show that the number of pathological gamblers in 2014 was 27,955, which is 0.09% of the Polish population over the age of 15 years. The most popular gambling games are lotteries, followed by scratch cards, SMS lotteries, and EGMs (CBOS Report, 2012, 2015).

In Poland, those with gambling disorder are treated in the same facilities as people with drug and alcohol dependencies. There is a lack of facilities dedicated exclusively to people with gambling disorder. Moreover, very rarely do clinics have a special pathway of therapy dedicated to people with gambling disorder. If gambling disorder is comorbid with alcohol or drug dependence, a major concern is substance dependence (Dąbrowska et al., 2016). Treatment is provided by therapists trained in theoretical approaches to alcohol or drugs dependence (National Bureau for Drug Prevention, n.d.b; The State Agency for the Prevention of Alcohol-Related Problems, n.d.b).

People with gambling disorder, similar to those with alcohol or drug disorders, can receive inpatient or outpatient treatment as well as non-medical support, specifically through Gamblers Anonymous. Professional services are based on psychological treatment, that is, behavioural, cognitive and cognitive-behavioural approaches (National Bureau for Drug Prevention, n.d.a; The State Agency for the Prevention of Alcohol-Related Problems, n.d.a). Less common is pharmacological treatment. The availability of brief intervention and programmes aimed at reducing gambling is marginal and only on offer in the private sector.

The number of patients treated for gambling disorder in Poland has consistently increased for many years. In 2015 almost 5000 Poles were treated for gambling disorder. The number of patients has grown 4.5 times since 2008 when around 1000 people were treated. This systematic increase in the number of patients has influenced treatment costs. In 2015, the cost of treating patients with gambling disorder was ten times higher than in 2008 when it was estimated to be around 100,000 euros. At that time, the cost of treatment of a single patient doubled (National Health Fund, 2016).

Sample selection

We adopted a qualitative perspective in our study to help explore a diversity of motives, opinions, behaviours, and events that have impacted on the researched phenomenon. Qualitative studies do not need to meet the rigorous demands for representativeness as quantitative studies do, as the aim is to capture the diversity of opinions and to achieve the desired level of saturation of the studied issues (Rhodes, 2000). The adoption of a qualitative approach in the study of the determinants of those seeking treatment will potentially highlight a broader spectrum of circumstances and possibilities, which are not possible to discern with the use of quantitative techniques.

Purposive sampling procedures were employed to recruit the respondents. Such sampling is non-random: not all members of the population have a chance to participate in the study. The aim of purposive sampling is to recruit respondents who will possibly provide full and comprehensive information on a particular subject (Wasilewska, 2008). The study sample consisted of people treated in outpatient clinics; by general practitioners, psychiatrists, and therapists employed in outpatient clinics; and by social workers from social welfare centres. Patients provided information based on their treatment experiences, while professionals provided information based on their contacts with those undergoing treatment.

The respondents were recruited in facilities located in Warsaw, Poland. The sample consisted of 90 respondents and covered 30 patients with gambling disorder and 15 people within each professional group. The number of respondents in each group guarantees a rich enough collection of data for a qualitative study in the field of

addictions (Moskalewicz & Welbel, 2013). The data were collected in the first half of 2015.

The inclusion criteria for patients was based on the diagnosis of gambling disorder according to the ICD 10 manual as confirmed by psychiatrists, while the main criterion for professionals was their status of employment in a treatment facility and the nature of their profession. Some professionals, such as social workers, very rarely meet people with gambling disorder, so their own limited experience of working with gambling disorder patients was not an inclusion criterion. Those who did not have such experience underlined this.

Patients were selected in outpatient clinics dedicated to alcohol abuse and drug dependency, and at Gamblers Anonymous meetings. In the outpatient clinics respondents were recruited by professionals. The information about the study and inclusion criteria for people with gambling disorder was forwarded to professionals. They were enrolled during individual and group sessions. Those who were interested in participating in the study left their phone numbers to be forwarded to researchers. At GA meetings, information about the study was relayed by the leader of the group, and those who were interested in participating made direct contact with the interviewers. The fulfilment of inclusion criteria was confirmed by interviewers. Professionals were enrolled in their place of employment. Researchers contacted professionals by phone or email on the basis of website information, while therapists were found on databases containing contact details for relevant facilities. The invitation with information about the study was forwarded to professionals, and those who accepted were contacted.

Characteristics of the sample group

The vast majority of respondents in the group of people with gambling disorder were male; 10% ($n = 3$) were female. The gamblers' average age was 38.3 years. Two thirds (60%, $n = 18$) of the participants had university degrees, almost a third (30%, $n = 9$) had secondary-level education, and every tenth had vocational education. There were no respondents with only a primary level of education. The most popular gambling activities (according to answers: "often" and "very often") in the last 12 months were slot machines (57%, $n = 17$), casinos (53%, $n = 16$), and online gambling (43%, $n = 13$). In turn, the least popular (referring to the answer: "I did not gamble") were horse race betting and SMS lotteries (77%, $n = 23$; 73%, $n = 22$ respectively), as well as sports betting without using the Internet (53%, $n = 16$).

The vast majority of professionals were female (70%, $n = 42$); a third (30%, $n = 18$) were male. The average age was 42.9 years and varied by group. Psychiatrists were the oldest group of professionals with an average age of 44.4 years, and the youngest were therapists with an average age of 40 years. The average age for GPs was 43.7 years, and for social workers 42.9 years. Most of the professionals were from Warsaw; only a few lived outside the city.

Research tools

Three types of categories were prepared to conduct semi-structured interviews: the first was tailored to people with gambling disorder, the second to social workers, and the third to professionals employed in the medical sector, that is, GPs, psychiatrists, and therapists. These categories were prepared to collect answers to research questions, and were formulated after literature reviews which preceded the fieldwork.

The categories relating to interviewing people with gambling disorder were divided into six sections: (1) experiences with treatment which addressed factors determining reasons to seek treatment, attempts to seek help outside the treatment system, reasons for choosing specific facilities, problems with obtaining help and access to professionals, and facilitators influencing the availability of treatment; (2) assessment of the available treatment for people with gambling disorder, in particular positive

and negative experiences in terms of degrees of satisfaction with the therapy and its effects; (3) social perceptions of people with gambling disorder based upon personal convictions; (4) recommendations for improving treatment; (5) intensity and severity of playing in various gambling games; and (6) comorbidity.

Categories for social workers included questions on: (1) reasons for those seeking help in the social welfare sector; (2) assessments of existing services in social welfare centres; (3) experiences of those seeking help in social welfare centres, in particular perceptions of barriers and facilitators in the receiving of assistance as well as experiences with seeking help outside the social welfare sector; (4) social perceptions of people with gambling disorder from the perspective of social workers and the influences of "attached stigma" on perceptions of the general public; (5) comorbidity issues; and (6) recommendations for improving services in the social welfare sector.

The final type of category was tailored to therapists, general practitioners, and psychiatrists. The issues discussed covered: (1) factors and circumstances of seeking treatment; (2) assessments of available services for helping people with gambling disorder; (3) experiences of contact with representatives from the treatment sector, in particular reasons for the choice of facility, as well as the barriers and facilitators identified during the process of undergoing treatment and the seeking of help outside of the medical sector; (4) perceptions of gambling and people with gambling disorder, and its influence on a spectrum of outcomes; and (5) recommendations on improving the situation in the treatment sector.

All the various types of categories included sections which allowed for the collection of sociodemographic data such as age, place of residence, marital status, educational level, and employment.

The average time of the interviews conducted with people with gambling disorder was 30 minutes; with the professionals it was 25 minutes. Interviews were conducted by five experienced interviewers (three sociologists and two political scientists specialising in prevention). They participated in short training sessions where the protocol of the study and the categories were discussed.

Data analysis

All interviews were recorded and then transcribed. The data were analysed by researchers involved in the study. Each interview was analysed by two researchers. After an analysis of the first three interviews, a matrix of codes was created. Additional codes which appeared during the analysis of subsequent interviews were unified and merged during negotiations. Analysis interviews by two researchers allowed maintenance of triangulation and reduced the risk of missing particular codes. Additionally, the use of various types of sources of data (patients and professionals) to answer research questions may have enhanced our understanding of particular phenomena by delivering various accounts and perspectives, as well as improving the comprehensiveness of the data (Barbour, 2001; Mays & Pope, 2000).

Qualitative analyses were conducted based on methodologies described by Miles and Huberman (2000), distinguishing between two levels of coding. At the first level, codes (such as GP referrals, family pressure, debts) were assigned to certain parts of the text. At the second level, the researchers summarised identified codes and aggregated them into thematic sets (i.e., external motives for undertaking treatment, recommendation of facilities, perceived barriers) according to the issue they referred to. Sets were assigned to broader sets or dimensions (i.e., motives for change, motives for facility choice, availability of treatment).

Interviews were analysed to cover the respondents' perspectives from all the sample groups. This approach allowed a presentation of a wide range of factors which bring people to seek treatment. It also helped avoid repetition of determinants mentioned by representatives of particular study samples. Issues specific to

particular representatives were mentioned and underlined. Interviews were not compared across the various study samples.

Analyses concentrated on factors affecting the decision about treatment and choice of facility, barriers which arose when people with gambling disorder sought to receive treatment, and the facilitators which increased the likelihood of undertaking treatment.

Ethics

Ethical approval to conduct the study was obtained from the Bioethical Commission of the Institute of Psychiatry and Neurology from Warsaw, Poland (ref. 24/2015).

The study was anonymous, participation was voluntary, and the respondents were denoted only by a number. Detailed personal data which could identify respondents were not collected. Respondents did not receive remuneration for participation. Before the interview, all respondents received detailed information about the study, in particular its objectives, anonymity, contact persons, and assurances of confidentiality of the data. Written informed consent was obtained from all respondents.

Results

Motives that trigger change

People with gambling disorder have typically experienced many years of negative consequences of gambling without seeking help. The decision to begin treatment was, among the interviewees for this study, generally made when problems started to concern many areas of life and become so severe that they could no longer be disregarded and they were unable to carry the weight of the increasing problems by themselves.

> I think it [taking treatment] could be in various situations. I actually treat people who are in huge crises, for example when they have lost their jobs, homes, or contact with the family, who can no longer stand the debts and the creditors who bother them. These are situations when their whole lives have started to collapse. (T2603F2)[1]
>
> I have robbed many people, and problems in relationships have started as well as problems with the family. All the consequences have then accumulated. (PG3003M2)

Even at this point, in the opinion of various groups of professionals, people with gambling disorder rarely seek treatment without external pressure. However, according to those with gambling disorder themselves, decisions about changing their behaviour were taken as a result of their own reflections. The sense of guilt arising from the non-fulfilment of social roles such as parenting and an inability to provide a sense of security for their families were recognised as sources of internal motivation for change.

> At that time [when I gambled] I was in a relationship with a woman and we had a baby. I could not watch them suffer because of me, by what happened in our life, by a lack of safety. One situation was shocking for me, when I came back home after gambling and my son lost consciousness. I called the ambulance, but I was without any money. After that I felt devastated, it was hard to sustain for me. (PG2204M1)

Representatives of all professional groups mentioned that decisions to seek treatment were triggered under pressure from significant others, that is, a partner or parents. Pressure from family members is an external motivation which does not come under the notion of self-reflection. Sometimes, families have thrown out and disowned problem gamblers from their homes, or their partners have threatened divorce or separation. This happens when families are tired of the problems caused by gambling or when the problem, hidden for many years, suddenly becomes apparent. Social workers said that other family problems, such as violence, are a motive triggering change.

> Some patients undertake treatment under pressure by their closest persons, spouse, partners,

children, and it depends on the age of the patients who have a gambling disorder. (GP0503F1)

A crucial motive for change, raised by those with the disorder and by professionals alike, were financial problems associated with not settling debts with banks, loan sharks, and friends and family members. Additionally, debts included rent arrears, which could result in eviction and lead to homelessness. Other financial problems, resulting from the necessity of having money for gambling, included theft of the family budget, defrauding public spending or business income, and even selling off household items and appliances. Sometimes, obtaining funds for gambling led to legal problems.

I brought myself into a credit spiral and to bankruptcy in general. (PG2505M1)

Losses which patients sustain as a result of gambling come from a spiral of debt, and when they are out of money, when the loan holders appear, they are left standing against the wall and have less and less possibilities to get money. These are clear motives behind undertaking treatment. (PS2804M2)

Legal consequences motivate them to seek help. For example, someone is caught stealing and is arrested and so on. These behaviours occur because all the time they are looking for money. (PS2805M1)

Other groups of problems which could affect the process of seeking treatment are emotional and mental issues. General practitioners, psychiatrists, and therapists mentioned depression, suicide attempts, anxiety, and comorbidity of alcohol dependence as factors which could accelerate such decisions. Among the emotional motives for change, psychiatrists identified such experiences as pain, suffering, anxiety, fear, remorse, and guilt.

When they lose money, stress appears, the negative mood deepens, and when the family imposes pressure, they start to seek help. (GP2302F1)

People with gambling disorder have depressive syndromes, sometimes they try to commit suicide. This is from the perspective of a mental hospital, where the effects of emotional problems are visible, and during the treatment process it is noticed that gambling was the cause (PS2301M1).

GPs added to the list of motives somatic syndromes for which it was difficult to find a cause, such as headaches, abdominal pain, sleep disturbances, and palpitations.

People with gambling problems complain about sleep disorders and neurotic ailments such as insomnia, palpitations, tightness in the chest, anxiety, and various somatic disorders, i.e. backaches. (GP1604F2)

Factors determining choice of facility

Before people with gambling disorder begin treatment, they or their relatives/significant others look for facilities which meet their expectations. This study indicates that the decision about choosing the facility is undertaken by either those who suffer from the gambling disorder themselves or by their life partners, spouses, or close family members, for example when they decide to pay a fee for treatment in a private facility. People with gambling disorder are also referred to a specific facility by specialists such as GPs, social workers, and psychiatrists.

The same determinants may affect the choice of facility, both by people with gambling disorder and by their relatives/significant others. These determinants can be divided thus: availability; living arrangements and quality of treatment of the facility; and the knowledge and opinions about provided assistance; and actual experienced problems.

Availability and access. People with gambling disorder frequently mentioned that the choice of facility is often determined by practical issues such as distance from their place of residence,

the possibility of participating in individual or group therapy sessions at flexible times depending on duties (i.e., before noon or at the weekends), and lower prices or even free treatment.

> I got a referral to a facility near my home. I would ride on my bike for about 15 minutes, which was quite close. (PG1605M1)
>
> The main reason I chose the facility was that the treatment was free of charge. My debts did not allow me to start treatment in different places, far away from home. (PG2603M1)

Living arrangements in facilities and quality of treatment. In the opinion of professionals, private facilities are chosen mainly because of the living arrangements which are better than in the public sector. In the context of private sector respondents, it emerged that greater availability of therapists and provision of increased confidentiality and discretion compared to public facilities also played a part. Such factors determining the choice of facility were underlined by GPs and therapists in particular.

> Some patients think that in private facilities they will be treated better than in the public sector. They claim that if they pay for treatment they must offer something special, a better standard. (T2703M2)
>
> People with gambling problems think that the private sector is able to ensure better anonymity, there is no need to set up a medical history, and visits will not be registered. (. . .) Patients are looking for a facility that guarantees them that information about their gambling disorder does not go beyond the four walls. (T2703M2)

Knowledge and opinions on provided assistance. Personal knowledge about the market of treatment services may determine the choice of facility. Social workers mentioned that those who are better oriented toward the possibilities of receiving assistance or treatment look for help in specialised facilities, because this allows them to shorten the path to obtaining help.

The source of information about therapeutic services is mainly the Internet and GA meetings. People with gambling disorder search not only for contact details for facilities, but also try to find views on particular clinics and about therapists from former patients.

> I started by participating in meetings of Gamblers Anonymous, where I ended up through an Internet forum. In the meetings, other participants told me where I should go, which facility I should choose, that there are open and closed therapies as well as inpatient and outpatient facilities. (PG1504M1)

A good reputation and experience in the treatment of people with gambling disorder were also factors determining the choice of facility.

> Ninety percent of people with gambling disorder are treated in [name of the facility]. This is the most famous facility in Warsaw, and therapists there have the most experience. (PG0605M1)

Actual experienced problems. The type of problems experienced also influences the choice of service. In the opinion of social workers, the services provided by social welfare centres primarily benefit those who are unfamiliar with the services of the psychological sector or those who experience financial problems. In general, the services of social welfare centres are linked to issues of poverty.

> For sure, those who are looking for financial support will visit a social welfare centre. Their living conditions are so difficult that they cannot even afford to provide for basic needs. So, it could be the reason for seeking help at our place, and for sure because of the debts arising from the non-payment of rent; this is a situation which could be supported by us. (SW2904F1)
>
> I think that those who end up without any means of subsistence, abandoned by a family or who live in a family which is no longer able to

help them, visit our social welfare centre. (SW1002F1).

GPs also claimed that the choice of facility and specialists depended on the disorders which needed solving most urgently. If people with gambling disorder had somatic problems, they would go to primary care. But if a patient recognises that their main problem is a gambling disorder, they will go to a psychiatrist or psychologist.

Psychiatrists found that in practice choice was limited because the treatment services for people with gambling disorder are quite narrow. People do not want to wait too long to start treatment, so they decide to accept what is available.

Barriers appearing during the treatment process

Decisions about treatment can be postponed due to various barriers which people with gambling disorder meet while they are considering a facility. Barriers identified by respondents can be divided into two main types, individual and structural. Individual barriers include emotions and convictions which can complicate treatment, whereas structural barriers are related to the treatment on offer, living arrangements in the facility, personnel, and therapeutic programmes.

Individual barriers. Among the individual barriers identified by professionals and people with gambling disorder were factors such as shame and fear of talking to others about personal problems, emotions, feelings, or experiences. Treatment in a psychiatric facility is also connected with a greater sense of stigma and is associated with the label of "mentally ill".

I was at two meetings with a psychologist and she referred me to a therapeutic group. I was ashamed go there and resigned from the treatment. (PG0605M1)

I am ashamed of my dependence, I never talk about it, and don't draw attention to it. I think that if you can't manage your own life, you're a little bit worse than others and, as such, sick. Some people have this "valid" conviction that if someone is sick, they are a little bit worse than others and I do not want to be treated as someone worse, I want to be normal and treated as a normal person. (PG3103M1)

Therapists claimed that people with gambling disorder did not believe that they might be dependent on gambling and if their problems worsened, they would manage without professional help. This results in a lack of self-motivation to start treatment.

People with gambling disorder stressed that they felt lonely, marginalised, and misunderstood for being treated in the same therapeutic groups as people with alcohol and drug dependence.

Structural barriers. More often than not, the respondents identified barriers with structural characteristics. The most common structural barrier identified by respondents from almost every category was a lack of treatment services for people with gambling disorder in outpatient clinics. Very rarely do facilities have services designed exclusively for people with gambling disorder. In most cases they seek help in treatment facilities for alcohol- and drug-dependent people, and therapeutic services in such places are perceived as inadequate, focused on psychoactive substances, and not tailored to their needs.

There are different facilities which offer therapy for alcohol dependency or for dependency on other psychoactive substances, including opioids, stimulants, new psychoactive substances, and so on. There is a lack of treatment services addressed directly to people with gambling disorder. Sometimes it is a very modest service and consists of individual meetings conducted in outpatient clinics. With regard to inpatient treatment services, this is a typical situation for alcohol-dependent persons. (PS2805M1)

As a result, the treatment of those with gambling disorder often occurs in the same facility as for patients with substance disorders. In these structured therapeutic groups, people with gambling disorder are in a minority, which invariably means that the group therapy programme primarily focuses on alcohol and drug disorders. Similarly, educational materials are primarily designed and dedicated toward the treatment of alcohol and drug dependency. These issues were raised both by therapists and by those with gambling disorder.

> As I had already began the treatment in the facility, the whole therapy was focused on alcohol addiction. Even drug-dependent patients or patients like me with gambling disorder had to focus on alcohol addiction. (PG1605M1)
>
> The educational materials are incorrect. I think the materials should be changed and adapted for patients with a gambling disorder, because they only address alcohol dependency and it could be a problem. (T0705F1)

From the patient perspective, the number of participants in therapeutic groups is seen as an important issue and influences the quality of the treatment. People with gambling disorder claimed that therapeutic groups were overcrowded and there was not enough time to speak about the problems or to exercise practical skills. Also, the schedules of therapeutic groups did not always fit in with the commitments of everyday life, especially for those who worked afternoon shifts. This results in absence at meetings and, as a consequence, an inability to continue group therapy. Additionally, outpatient clinics are closed at weekends, which also impacts on availability.

Therapists and patients said that there was not always treatment for people with gambling disorder that was free of charge. Especially those without health insurance could not begin treatment as they very often could not afford it. Sometimes, people with gambling disorder undergo treatment more akin to that given for substance disorders, because treatment for this group of patients is reimbursed, even without health insurance.

> If the National Health Fund refunds treatment for alcohol- and drug-dependent people who are uninsured, I am surprised that this is not the case for people with gambling disorder where the problem of lack of insurance is common. (PG3003M2)

People with gambling disorder mentioned long waiting times for their first meetings with therapists. Decisions made about seeking treatment could change if the initial meeting is postponed due to queues and long waiting times.

Respondents also identified barriers related to the staff at the facility. People with gambling disorder have a feeling that therapists do not have enough experience and knowledge about the desired treatment. A typical approach is based on therapeutic paradigms designed for the treatment of alcohol- and drug-dependent people. A lack of knowledge on the phenomenon of gambling disorder was confirmed by therapists. They do not feel prepared to provide assistance. In some facilities staff do not trust patients, which creates an atmosphere of control. The patients had to explain every absence from therapy.

General practitioners, psychiatrists, and social workers identified barriers characteristic of their places of employment. GPs are not always aware that they are dealing with people with gambling disorder. They do not conduct screening tests and do not ask patients about gambling. Additionally, this disorder is "invisible" during medical examinations. The diagnosis of problematic gambling is also difficult because of the duration of the appointment which often lasts no more than 15 minutes. GPs also do not want to conduct diagnoses of gambling disorder because they do not have enough knowledge about it and do not know about specialised treatment services. The GPs said that even the patients did not know that they could speak about gambling with their doctors, as the GPs were perceived as

specialists of somatic disorders. GPs felt that gambling disorder was a more personal issue than smoking cigarettes or drinking alcohol.

> I do not know how to treat patients with gambling disorder, I have no idea what I can improve, I have no experience and knowledge. (GP1902F1)
>
> I ask about alcohol and cigarettes but I do not ask about gambling because it could be seen as interfering in privacy. Would you like somebody to ask you about that? (GP1604F2)

Treatment by psychiatrists is connected with a sense of stigma, but most of the barriers identified by psychiatrists are related to the availability of psychiatric treatment. Patients do not know that treatment in this sector does not require referrals. The long queues in psychiatric outpatient clinics extend the waiting time for treatment. This is the result of staff shortages: psychiatrists, more often than doctors of other specialisations, are moving to the private sector.

> The barriers from our side, what I know and patients do not know, are frequent problems with staff, especially when it comes to medical staff. Among therapists the situation is a little bit better. I can observe a tendency toward moving to the private sector. (PS2805M1)

Specific barriers were also identified by social workers. Social welfare centres are associated with clients who suffer from poverty and are socially marginalised. People with gambling disorder do not know that the services of social welfare centres are much broader and by no means limited to providing financial support.

> They do not even think that such an institution as social welfare, which is associated only with helping poor people with low material status [can help them]. They feel they would have to be very desperate to come here. (SW1002F1)

The percentage of people with gambling disorder in social welfare centres is so low that social workers do not have experience in working with them. The problem does not "exist" in questionnaires or on application forms and is not recognised in social diagnoses. As a consequence, social workers do not recognise this problem among their clients. People are required to fulfil obligations in return for provided assistance. They are obliged to cooperate with a social worker in solving their difficult life situations and have to inform them of changes in their personal and financial situations. Failure to comply with the arrangements included in the contract may result in reduced benefits. The interference of social workers in private life and their attempts to control it may result in patients' refraining from the use of services. Additionally, social workers may have concerns that granted funds could be wasted by an "allocation" for gambling, and as a result they are reluctant to provide that kind of support.

Facilitators appearing during the treatment process

There were only a few facilitators identified by respondents which influenced the receipt of treatment in addiction treatment facilities. Similarly, as in the case of perceived barriers, facilitators can be divided into individual and structural types.

Individual facilitators. Individual facilitators that the treatment offered included possibilities for exploring emotional states, and identifying personal problems and ways of solving them. This had a positive influence on patients coping with problems in life. Therapy provides knowledge about disorders as well as of mechanisms and methods of preventing relapses.

> When I returned to gambling, it was much easier for me to come out after that experience [with treatment]. (PG3003M2)

Individual facilitators related mainly to treatment in the private sector with a greater sense of assured confidentiality and discretion.

Structural facilitators. Free treatment offered to people with gambling disorder was felt to be a facilitator. Additionally, when people with gambling disorder undertake treatment, they do not need a referral from GPs and psychiatrists, which thus ensures them anonymity.

> For outpatient treatment, you can go straight away and it is free of charge. Even if you do not have insurance. They somehow introduce you to the treatment if you are alcohol-dependent, and 90% of people with gambling disorder are alcoholics, so they have treatment for free. (PG0605M1)

Structural facilitators related to the organisation of the treatment system provide diversification in terms of forms of therapy. People with gambling disorder can choose between treatment in outpatient or inpatient clinics for people with alcohol or drug disorders, individual therapy in outpatient facilities, therapy offered in day-care services, and the support offered by the GA programme. Treatment in outpatient clinics means that people with gambling disorder do not need to leave their social environment or give up their daily activities and work or spend time away from their families.

> In the outpatient clinic I don't need to come every day, but just once or twice or sometimes three times a week. I live normally in society, fulfil professional obligations, and maintain family relationships. In contrast, in an inpatient clinic it would be difficult to continue such regular, everyday routines. (PG0806M1)

In some outpatient clinics the waiting time for treatment is short; it takes about a week to begin therapy. Those who had such experiences claimed that it helped them to start treatment.

> It started fairly quickly, as I got a referral here to the outpatient clinic. The lady [receptionist] told me that I should come in the next three to four days. (PG1605M1)

When they qualify for treatment at an outpatient clinic, people with gambling disorder are consulted by therapists and psychiatrists during the same day and in the same building, so the patients do not have to come back the next day. This accelerates the undertaking of therapy. Good first contact with therapists helps people with gambling disorder to make a decision about starting treatment, according to the patients themselves. Patients and therapists also maintain that there are an increasing number of professionals involved in the treatment of gambling disorder, which improves the availability of help.

> The most important thing [was] the initial contact with patients, in that they came to us and something persuaded them to stay here, and the fact that the visit did not discourage them. Initial contact, both face to face and by phone, is very important. (T2603F1)

Many facilitators were identified by social workers regarding access to social welfare centres: the most important factors were the opportunity to obtain free assistance, financial support, no queuing, knowledge among social workers about the treatment on offer, and the mechanisms of help provided in social welfare centres.

> Due to the appearance of gambling disorder many problems occur such as care and educational problems in the family, the loss of jobs, and financial problems. Social welfare centres can generally help with most of these difficulties. We refer those who have gambling disorder to a specialised facility, but we have solutions for their problems in many other areas. In treatment facilities people with gambling disorder can obtain help in just one sphere, however they can obtain assistance in many fields and not just for them, but also for their family. (SW1201F1)

Psychiatrists drew attention to the benefits of treatment in private facilities offering, for example, pharmacotherapy which helps to improve the patients' emotional functioning.

General Practitioners highlighted the fact there is a lack of regionalisation of treatment, so people with gambling disorder can undertake it anywhere and not only in their own residential district. They also pointed out that in some facilities the departments of dependence treatment are part of a healthcare centre and employ therapists and psychiatrists. Within one facility, then, consultations can be obtained for various health problems.

Discussion

Our study identified both internal and external motives to undertaking treatment. Most of the motives can be classified as external. Negative consequences which appear during a gambling biography concern many areas of life and become so severe that they can no longer be disregarded, and those with gambling disorder are no longer able to carry the weight of the problems by themselves. Family relations or troubles in relationships, as well as financial problems, were the most frequent motives cited by problem gamblers, which is consistent with the results of various studies on the field of gambling and alcohol dependence (Gainsbury et al., 2014; Suurvali et al., 2009; Suurvali et al., 2010; Suurvali et al., 2012a). During the treatment process external sources of motivation should be converted into more internal factors to help to achieve the desired goals (Prochaska et al., 1992). Internalised sources of motivation are also associated with greater patient involvement and an increased retention in treatment (Ryan, Plant, & O'Malley, 1995).

Social workers underlined the fact that the occurrence of other family problems such as violence can be an external motive triggering change and initiating the seeking of help. This motive may be rather denigrated as there can be a sense of shame when talking about such acts of violence. Debts were also an external motive for undertaking treatment and were connected with legal problems. In studies conducted by Gainsbury et al. (2014), legal problems appear as a motive for change, but the authors do not define the source of these problems.

Respondents in our study failed to mention, unlike in other studies, that significant motives for change were the concerns voiced by gambling venues (Gainsbury at al., 2014). People with gambling disorder were unaware of what gambling venues had to say about patterns of play, and even if they are aware of such comments, they may choose to ignore them and change the venue.

Compared to the findings of Suurvali et al. (2010), the respondents in our study paid relatively more attention to external motives than internal drivers (which included such motives as a sense of guilt arising from the non-fulfilment of social roles and, based on this, decisions about quitting or reducing gambling).

Before people with gambling disorder begin treatment, they or their relatives/significant others try to find the facility that will meet their expectations. The availability of such facilities is sometimes limited and depends on any perceived barriers along with the facilitators who will be initially approached (Dąbrowska et al., 2016; Gainsbury et al., 2014). Individual barriers recognised in our study are largely similar to those identified in other studies, with the exception of a lack of awareness of services (Evans & Delfabbro, 2005; Suurvali et al., 2009). But this may also be because we conducted interviews with respondents already in therapy or with a lot of experience of such treatment. Shame and fear of stigmatisation were factors that often appeared in the statements of respondents, and this is consistent with the findings of quantitative studies by Suurvali et al. (2012b) and Hing, Russell, Gainsbury, and Nuske (2015). Similarly, as with alcohol- and drug-dependent people (Dąbrowska et al., 2016; Wieczorek, 2015), fear of stigma among people with gambling disorder stops them from seeking treatment. A sense of stigma is associated with being labelled as an "addict" as well as being a patient of a psychiatric facility (Dąbrowska, Moskalewicz, & Wieczorek, 2017). However, it seems that the sense of

stigma among people with gambling disorder is not as strong as among those addicted to alcohol and drugs. The majority of identified barriers were structural, covering those identified in international studies. However, some issues related to the availability of treatment, including a lack of more specific treatments, the necessity of participation in therapeutic groups alongside people with substance disorders, the concentration of therapeutic programmes, and the provision of educational materials on psychoactive substances, are specific to this study.

While our study includes perspectives of various group of professionals, the barriers that these professionals identified are different from those raised by people with gambling disorder. The identification of barriers in primary health care, mental health services, and social welfare centres is important for recognising the disorder at an earlier stage and for the referring of patients to specialised facilities. Most of the barriers identified by the professionals in our study are new and fill the gap in scientific knowledge. Only barriers such as a lack of knowledge about gambling disorder, about the places where gamblers can be referred to diagnose the disorder, and an ability to provide patients with a diagnosis, were similar to those identified by Sullivan et al. (2000).

Our study found no barriers related to geographical location, but this may be associated with the place of research, i.e., a large city where the public transport infrastructure is well developed. The other reason is, as was identified in studies from the field of alcohol disorders (Dąbrowska et al., 2016; Wieczorek, 2015), that people with gambling disorder choose facilities which are located some distance from their place of residence primarily because of a fear of stigmatisation. Despite so many structural barriers, individual barriers are the most salient and the most difficult to overcome (Gainsbury et al., 2014; Hodgins & el-Guebaly, 2000; Suurvali et al., 2012b).

There is a gap in knowledge related to the facilitators which favour the undertaking of treatment, not only in the field of gambling studies but also in the broader context of addictions. Most studies focus on problematic barriers preventing treatment, along with an apparent disregard of facilitators. Facilitators improve the undertaking of treatment as well as influencing and "shortening the path" toward facilities. The results of several studies from the field of alcohol dependence, which are to some extent comparable, have identified facilitators different from those in our study. Browne et al. (2016) pointed out as facilitators integrated services which meet clients' holistic needs such as housing, employment, help in obtaining appropriate clothing for job interviews, and flexible operating hours. These mainly relate to improving living conditions. In turn, facilitators identified in our study concern mainly the availability of treatment and therapeutic services. This may pertain to the extent of health and social consequences and implications suffered by these two groups. Alcohol-dependent people undertaking treatment generally experience more severe damages than those with gambling disorder.

The study has some limitations in that only those who already had experience of gambling treatment took part. The identified determinants did not include the perspective of people who had never accessed treatment or those who had failed to access it. This makes it impossible to recognise the opinions about the determinants from those who did not undertake therapy. Their opinions may be different.

The recruiting procedure of people with gambling disorder may also have had an impact on the answers of the respondents as they were recruited via therapists. Therapists could select the respondents and choose those with better results from treatment. Their statements may have been different from those not satisfied with the treatment. However, the study also includes respondents who were not directly recruited by therapists.

The method of choosing treatment units could be considered as a limitation. In Warsaw there are a limited number of facilities which provide treatment for people with gambling

disorder. This may limit the scope and range of experiences of those who undertook treatment as they have contact only with a limited number of facilities.

The number of individuals approached for the study or of those who refused to participate was not monitored. The response rate could therefore not be calculated.

The personal beliefs and perspectives of the interviewers, the times allocated to conduct the interviews, and the manner of conducting the interviews (the nature of how the questions were asked) could all have had an impact on our study. The influence of interviewers on the quality of data was, in a limited way, restrained by the semi-structured and pre-determined nature of the dispositions. Also, the scheme of interview coding by the researchers may have influenced their analyses, as they may show bias in striving to confirm their hypotheses. This is a common objection when analysing qualitative methods; something which quantitative methods try to avoid.

Conclusions

Our study has identified a number of factors related to the motives of those seeking treatment for their gambling disorder, motives behind the choice of facility, the perceptions of barriers, and the facilitators that appeared during the treatment process. Identifying these factors may contribute to improved availability and quality of help, which could lead to more patients undertaking treatment. Identifying these factors is also important for increasing the chances of earlier inclusion in treatment programmes and the welfare system. This allows and facilitates action against the intensifying nature of problems arising from gambling disorder. The recognition of factors determining the choice of facility, and the perceived barriers and facilitators that may have appeared during the treatment process allow for a better understanding of the needs of people with gambling disorder and serve to improve the provision of services designed to help and treat addiction.

Work toward limiting the negative effects of barriers and developing and accentuating the positive aspects of facilitators should be undertaken at both national and local levels in terms of health policies, and should be considered by every single facility. Additionally, the positive identification of facilitators provides an opportunity to exchange knowledge and ideal solutions at both national and international levels.

Moreover, our study shows that there are professional groups (general practitioners, social workers) who only rarely recognise gambling disorder among their clients, primarily because of limited knowledge about the problem, various administrative limitations, and an apparent reluctance to make a diagnosis of gambling disorder. There is clearly a need for more education in society in general and among professionals in particular to raise awareness of the problem and to develop further the possibilities of assistance. In primary healthcare and social welfare centres, screening tests could help with the recognition of people with gambling disorder at an earlier stage of dependence. This would serve to minimise any potential harm.

Note

1. Method of coding: T – Therapist; PG – People with gambling disorder; GP – General Practitioner; PS – Psychiatrist; SW – Social Workers; XXXX – Number of the interview; M – Male, F – Female; Y – Number of the interview conducted on the same day.

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