“I’m the same as you”

The Experiences of CBT for Problem Gambling in South Asian Men:
An Interpretative Phenomenological Analysis

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Declaration

I hereby declare that the work submitted in this thesis is the result of my own investigation, unless otherwise stated.

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Abstract

Background/Aims

In the United Kingdom (UK), South Asians (SAs) are at a higher risk of developing problem gambling (PG), whilst rates of gambling activity remain the same across the population. Similar findings across other minority groups in Western jurisdictions indicate that culture and ethnic minority status may play a role in the development from recreational gambling activity to PG. However, there is a dearth of research into SA men's experience of cognitive behavioural therapy (CBT) for PG in the UK and elsewhere. Existing research suggests that SA men with psychological difficulties under-utilise mental health services in the UK. Understanding the experiences of SA problem gamblers who attend therapy could be integral in providing culturally appropriate interventions and adequate services where counselling psychologists work.

Design

Participants were seven second-generation SA men aged between 23 and 39 who had received individual and/or group CBT from a National Health Service (NHS) within the last year. Interpretative Phenomenological Analysis was applied to verbatim accounts of semi-structured interviews.

Results

Three superordinate themes were generated during analysis: 'Experience of CBT' (which refers to preconceptions of therapy, thoughts and challenges during therapy, issues of confidentiality); 'Culture' (which discusses stigma from the SA community, issues with identity and pressures from the family); 'CBT Framework for gambling' (which explores the learnings gained in therapy, addressing culture in therapy and advice for others).

Conclusion

Participants emphasised the issues that SA men can encounter in therapy for PG with regards to cultural factors. These included adhering to collectivist and British values, meeting family and community expectations whilst negotiating their identity, and in reconciling stigma towards gambling. It is therefore suggested that training facilities and practitioners should consider developing more directed interventions, such as individual therapy, to better address these clients' cultural needs.

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Glossary

A&E	–	Accident and Emergency
ADHD	–	Attention Deficit Hyperactivity Disorder
APA	–	American Psychological Association
BBC	–	British Broadcasting Corporation
BPS	–	British Psychological Society
CBT	–	Cognitive Behavioural Therapy
CP	–	Counselling Psychology
DA	–	Discourse Analysis
DSM	–	Diagnostic and Statistical Manual
FOBT	–	Fixed Odd Betting Terminal
GAD	–	Generalised Anxiety Disorder
GT	–	Grounded Theory
IPA	–	Interpretative Phenomenological Analysis
NHS	–	National Health Service
NICE	–	National Institute for Clinical Excellence
NZ	–	New Zealand
PG	–	Problem Gambling
PGSI	–	Problem Gambling Severity Index
PHQ	–	Physical Health Questionnaire
SA	–	South Asian
SE	–	South East
UK	–	United Kingdom
US	–	United States

1. Introduction

Greater rates of gambling have been found globally, which coincide with an increase in accessibility, availability nd advertising of gambling and gambling itself seen as a socially acceptable activity (Shaffer, Hall & Bilt, 1999). There has also been an accusation of romanticisation in popular culture (Ellenbogen, Gupta & Derevensky, 2007). Expenditure has also been increasing globally (Venuleo, Salvatore & Mossi, 2014); and in 2009, the gambling industry created revenues of £225 billion worldwide (Datamonitor, 2010). As a result, there has been an increase in problem gambling (PG) in the general population (The Guardian, 2017). There has also been a recent shift from solely gambling-specific venues to readily accessible settings such as restaurants, or holiday resorts, not previously associated with gambling (Petry, 2006), and of course the prolific online gambling of today. Gambling has increasingly come under UK media spotlight with articles referring to fixed-odds betting terminals (FOBTs) as the 'crack-cocaine' of gambling (The Independent, 2014). There have also been published articles on the negative impacts of gambling amidst the growing number of gambling outlets appearing on high streets (BBC, 2016). This introduction begins with current media concerns and gambling behaviour trends, followed by the UK context. Finally, an understanding of PG related issues will be discussed along with its therapeutic associations.

1.1 Reflexive Statement

Personal and epistemological positioning will be addressed in the following reflexive statement, in order to maintain transparency and integrity. I am a 31 year old second-generation British Indian, who has lived in various multicultural places within the UK over the last 15 years and worked within a range of clinical settings. My interest in cultural backgrounds has been developed since childhood, particularly due to my own ethnic difference as a British SA in a predominantly white neighbourhood which emphasised a different set of values and beliefs to the ones being taught at home. My experiences made me feel that nobody quite understood my cultural dilemmas.

A more recent experience was the role of my culture in the therapeutic encounter with my personal therapist, who was from a different cultural background to me. I had openly mentioned my culture and discussed issues related to it, but I felt that my therapist did not feel the need to explore it without prompting. It was interesting to me that she did not feel the need to ask me more about this, and I got the sense that she felt uncomfortable. It made me think about the importance of not including or including culture in therapy. I wondered if other clients felt similarly or whether they negotiate other experiences. It is my personal feeling that therapists should feel empowered to address culture even if it may not be relevant to the presenting problem. It is the context of the individual which deems it important. I am also aware that I have chosen the construct of culture and that it is not necessarily salient in the experience of PG in the participant. The research takes its shape around my choices. I respect that other clients may not feel the same way and I must not let my strong opinion drive my investigation.

My original interest in gambling was developed whilst working within a secondary care NHS service primarily providing manualised CBT for PG in London. The political climate during my training has created a major upheaval in the delivery of psychological therapies within the NHS. There has been an emphasis on providing time-limited, evidence based treatments, recommended within National Institute for Clinical Excellence (NICE) guidelines. During this time, it struck me that clients had comorbid issues which were unable to be addressed in the limited time frame. This resulted in clients being referred elsewhere as they were unable to be seen on a long-term basis due to the limited resources and remits of services. This experience highlighted an issue that clients might not have been able to bring themselves to attend another facility and may have felt disenfranchised by the system. It occurred to me that those from different ethnic backgrounds may not have felt fully understood by professionals, instilling a belief that their cultural issues were unimportant, undeserving of attention or may have made the professional feel uncomfortable. This may have led to experiences of non-understanding or rejection of issues from someone in whom they have confided. 'Starting again' may not have been an appealing option. I believe the understanding of culture can provide a wealth of knowledge attributable to helping SAs to overcome their difficulties in therapy.

My experiences coming from an Indian family are unique compared to others' and cultural differences may play different roles in different people's lives. In line with this, my beliefs about knowledge resonate deepest with social constructionist epistemology due to attention to the way individuals' experiences and perceptions are influenced historically, culturally and linguistically, and that these may induce different understandings of the same phenomenon, none of which are wrong (Willig, 2008). Culture goes beyond a monolithic entity and has inherent variability within it, and participants actively negotiate their life-world in the specific position within their cultural context (Cohen, 2009). As a passionate believer in democracy, which maintains that everyone should be heard, that their input has equal value and no-one should experience prejudice, I want to allow descriptive accounts to be heard from a minority population that may otherwise be lost.

Although I believe that quantitative approaches are valuable in circumstances where things are considered 'measurable,' my interest lies with individual experience which is supported by qualitative views of searching for meaning from an individual's experience (Smith, Flowers & Osborn, 1997; Willig, 2013). Furthermore I critically view randomised control trials, considered to be the gold standard research tool in developing treatment guidance for mental health issues as recommended by NICE. I believe that this can overshadow the clinical nuances that might be presented in front of us and disallow us to travel to the heart of lived experience, which can offer us real-life understandings of a phenomenon. Counselling Psychology (CP) uses reflexivity to undo the limiting nature that a lack of understanding of one's own subjectivity can impose (Kasket, 2013). I believe that the alignment with the philosophical properties of Interpretative Phenomenological Analysis (IPA) methodology reflects this, as it offers an opportunity to explore individuals' experiences of undergoing CBT, as well as understanding the role culture may

play. I believe that my positions on reflexivity, epistemological stance and clinical practice are congruent and emphasise the individual as being the expert at making meaning for their selves. I have developed an integrative theoretical orientation in therapy, stemming from a wide range of paradigms, including psychodynamic, cognitive behavioural and person-centred approaches. Drawing upon these various theories during the meaning-making process may influence the process of analysis, which I attempt to reflect on and acknowledge. I expect that my identification with the participants as a second-generation South Asian Briton means it is essential for me to be aware of my preconceptions during interviews. Therefore, it is important to note that these findings are based on interactions between the participants and me, and consequently are expected to vary if replicated by another. This is due to the double hermeneutics of IPA (see Section 2).

1.2 Defining Problem Gambling

PG is categorised as a "substance-related and addiction disorder" in the fifth edition of the Diagnostic and Statistical Manual (DSM-V) (American Psychological Association (APA), 2013). It is defined as having three or more of the following difficulties: preoccupation and frequent thoughts about gambling; a need to gamble more in order to achieve the desired excitement; loss of control; withdrawal symptoms such as restlessness and irritability when attempts are made to cut down on gambling behaviours; gambling is used as an escape or relief from problems; chasing gambling losses by gambling more; lying to others in order to conceal the extent of gambling involvement; relationship or job difficulties; relying on others to relieve desperate financial situations. A problem gambler is defined as someone who gambles "to a degree that compromises, disrupts or damages family, personal or recreational pursuits" (as cited in Wardle, 2007, p. 72). Pathological gambling has previously been defined as meeting five or more of these criteria. In the DSM-V, however, this has been reduced to four after the omission of illegal acts to finance gambling. Disordered gambling has been defined as a category combining the two terms pathological and problem (Alegria et al., 2009; APA, 2013). As most of the research reviewed uses the PG criteria (often describing an intermediate or subclinical form of pathological gambling) due to its relatively distressing effects, this term will be used to reflect this.

1.3 Problem Gambling in the UK Context

In the UK, various governing bodies regulate gambling activities. The Gambling Act (2005) places social responsibility requirements on British-based gambling operators: to contribute to research, education and the treatment of PG e.g. training staff to recognise and appropriately deal with PG, and providing self-exclusion opportunities for players who seek it. The Gambling Commission (2007) regulates gambling alongside local licensing authorities by pledging to: ensure fairness; keep vulnerable populations from harm and exploitation; stamp

out crime and; provide independent advice to the government. These safeguards were put in place as a result of the growing concern from the saturation of the gambling market; however PG continues to rise.

Confidential self-completion questionnaires from 8,291 adults in the Health Survey for England (2012) and 4,815 adults from the Scottish Health Survey (2012) showed that 65% of adults had gambled in the past year. The measures reflected all forms of commercial gambling available at the time of completion. Fourty three percent of these had gambled on activities other than the National Lottery (Wardle et al., 2014). Furthermore, the internationally recognised DSM-IV and Problem Gambling Severity Index (PGSI) measures (APA, 2000; Ferris & Wynne, 2001) found the prevalence of PG to be 0.6 percent. When extrapolated, 700,000 adults in England and Scotland were calculated as being at moderate risk or problem gamblers. Being male, black/black British, Asian/Asian British and other non-white backgrounds were factors associated with PG. In a previous British Gambling Prevalence Survey (Wardle, Moody, Griffiths, Orford, & Volberg, 2011), being male and Asian/Asian British were found to be at highest risk of becoming problem gamblers. Problem gamblers were also more likely to be male, younger, have parents who gambled regularly and who had experienced problems with their gambling, and currently smoking (Wardle et al., 2011). PG rates in the UK appear to have been risen from the 2007 to the 2010 surveys from 0.6 percent to 0.9 percent respectively (using the DSM-IV measure), equating to approximately 451,000 adults. These surveys measured a wide spectrum of gambling activities; therefore, conclusions cannot be drawn concerning the extent of harm of individual gambling methods. A further one percent of adults in the 2010 survey were deemed to be at 'moderate risk,' demonstrating the potential target population and need for preventative strategies for PG. 9,000 British children were surveyed using a junior version of the DSM-IV gambling screening tool (British Survey of Children, 2009). Age group prevalence of PG was 1.9 percent, higher than adult rates found in the aforementioned prevalence surveys. Furthermore, significantly elevated probabilities of PG were found in SA children. This has implications for targeting help for children or adolescents at risk of PG, and specifically for children of SA descent. These surveys indicate that the SA culture may play a role in the development of PG.

1.4 Literature Review

The following review aims to critically evaluate the current literature on culture and PG in order to find a topic that will consequently add to counselling psychologists' understanding of this population.

1.4.1 Prevalence and Difficulties Associated with Gambling

A recent comprehensive review found gambling to have a global prevalence of 2% (Sussman, Lisha & Griffiths, 2011). Other global prevalence rates have been found to be between 0.4 and three percent (Bland, Newman, Orn, &

Stebelsky, 1993; Petry, 2006; Volberg, Abbott, Rönnberg, & Munck, 2001; Welte, Barnes, Wieczorek, Tidwell & Parker, 2001). A review looking at adolescents exhibiting PG found a global PG range of 0.12% – 5.8% and 0.2% – 12.3% (Calado & Griffiths, 2016). The greater social integration of gambling introduces a public health concern due to a wealth of issues within society and individuals associated with PG. Such issues include problem gamblers being at an increased risk of perpetrating domestic violence (Dowling et al., 2016, debts (Ladouceur, Boisvert, Pepin, Loranger & Sylvain, 1994), family and relationship difficulties, job loss, and criminality (Hoffman, 2011). Gambling has also been strongly associated with comorbidity of depression, suicidality, substance and alcohol addiction (Lorains, Cowlishaw & Thomas, 2011; Petry, Stinson, & Grant, 2005).

1.4.2 Psychological Theories of Gambling

Multiple models of gambling, that share common features, have attempted to explain differing sociological, biological and psychological processes of gambling. These may help us to understand the aetiology of gambling from being a recreational activity through to PG, associated with more debilitating consequences. Theories of addiction, psychodynamic and cognitive behavioural theories make up the most prominent concepts used to describe the phenomenon of gambling, and will be explored in more detail in the following section.

1.4.3 Theories of Addiction

Jacob's (1986) theory views addiction as the result of two interrelated factors predisposing individuals to addiction. The first of these factors is an abnormal resting state which leaves individuals under or over-aroused. Those with under-arousal may be susceptive to gambling problems due to a search for external stimulation allowing them relief from boredom. Regarding the second factor, Jacobs suggests that childhood experiences leading to a deep sense of inadequacy such as low self-esteem and feelings of inferiority predispose individuals to gambling problems. He asserts that both factors coupled with a conducive environment need to be present for an addiction to develop and be maintained. There has been growing consensus in recent years (Sussman, Lisha & Griffiths, 2011) that behaviours, including gambling, can be similarly addictive to substance misuse. Similarly to alcohol dependence, PG has been suggested as sharing phenomenological manifestations and a presence of withdrawal symptoms. However, the view that PG is a true physiological addiction has been rejected by many researchers, mainly due to the lack of identifiable physiological processes deemed necessary to account for a physiological addictions (Walker, 1992). Greater importance has been given to associating secondary processes, primary incentive motivation and tertiary effects of losses in the addictive process involved in PG (Blaszczynski, Walker, Sharpe & Nower, 2008), whilst neuro-adaptation leading to habituation and desensitisation, tolerance and withdrawal has been deemed as unimportant (Orford, Morison, and Somers, 1996).

Although shared markers have been recognised between gambling and substance misuse, such as cravings, tolerance, withdrawal and impulsivity, there are clear distinctions. The recent DSM-V classification of the newly coined gambling disorder as a behavioural addiction as disparate from substance use disorders reflects this (APA, 2013; Clark, 2014). PG appears to be more consistent with a cognitive interpretation of gambling in which accumulating debts, coupled with erroneous perceptions lead the gambler to increase bet sizes rather than a wish to generate desired levels of arousal or excitement.(Blaszczynski et al., 2008). Due to the unlikeliness that gambling addiction actively exerts damage on the brain, unique cognitive aspects may be more likely to provide insight into PG's addictive properties (Clark, 2014). Gambling-related cognitive distortions (see section 1.5.5) such as gambler's fallacy and illusion of control[1] related to chance remain unique to PG and may underlie its addictive potential. These specific gambling-related cognitions render research not fully transferrable between substance and gambling addiction. Unlike the visible, physical impacts of drug-misuse problems, which may be easier for an outsider to identify, problem gamblers may be enabled to hide their issues until disclosure. This "hidden nature" can cause greater financial damage in shorter periods of time and is more difficult to detect (Bond et al., 2016, p. 3) or be recognisable to significant others, and, effects can be profound on the well-being of individuals, their families and communities (Scull & Woolcock, 2005). Furthermore, in substance misuse, the body can trigger protective mechanisms i.e. vomiting and blackouts and in gambling, having the means i.e. money means the behaviour continues, and individuals have the capacity to lose a lot of wealth in a short period of time, which has implications for timely intervention (Liao, n.d). The financial role also provides PG with a unique difference in the 'chasing' characteristic i.e. returning to win back what has been lost, for which there appears to be no parallel to the chasing phenomenon in substance misuse (Stinchfield, 2002). Finally, the social and political climates are different for both phenomena i.e. resources are fewer for problem gamblers and may not be fully recognised by mental health professionals, whilst substance misuse has long been recognised as a public health issue with an illegal status.

Addiction models have been considered to pathologise everyday behaviours and have been widely criticised as stigmatising and internalising (Burglass & Shaffer, 1984; Griffiths & Larkin, 2004; Peele, 1980) a disease. It is a concern that this may absolve responsibility from individuals, if PG is seen as inherent part of them, because it may have implications for therapy engagement. This model also fails to take into account those problem gamblers who had no reported depression before initiation of the behaviour. The next section explores psychodynamic explanations of gambling.

[1] Gamblers fallacy occurs when a gambler observes sequences of random outcomes, and judges that the other possible outcome will come next i.e. when tossing a coin or throwing dice. However, the sequence will remain random in probability (Oskarrson, Van Boven, McClelland, & Hastie., 2009). Illusion of control ensues when a person focuses on irrelevant features pertaining to the game which creates a sense of developing skill or control in the gambler of an outcome ultimately determined by chance. This is associated with risky behaviours (Stefan & David, 2013).

1.4.4 Psychodynamic Theories

According to psychodynamic theorists, individuals engage in problematic behaviours such as excessive gambling in an attempt to resolve unconscious psychic conflicts. These conflicts are thought to be linked to early childhood traumas and deprivation, driving the individual to participate in gambling behaviours hoping to ease psychological pain (Fong, 2005; Upfold, 2017).

Attachment theorists provide one approach in the understanding and treatment of addiction (Flores, 2006; 2011). They assert that early attachment experiences with caregivers in addition to biological and affective experiences create a theory about the self and others. Bowlby (1973, cited in Holmes, 1993) states that internal working models are developed upon a judgement about self-worth. Over time, the infant learns what to expect within the relationship. Individuals with an insecure attachment style (i.e. did not receive enough nurturing during early stages of their life) will find it challenging to maintain self-esteem and attempt to regulate affect or emotion through gambling. Upon inevitable failure, relationship problems are reinforced from which the negative affective state originates.

Freud (1954 cited in Aasved, 2002) attributed gambling to unfulfilled oedipal desires and compared the excitement experienced to sexual arousal and a substitute for masturbation. In 1897 he also concluded that gamblers use masochistic self-punishment to relieve intense feelings of guilt i.e. playing to lose in order to redeem themselves and offset guilt, a theory also supported by Bergler (1958). Rosenthal (1987) identified defense mechanisms employed by problem gamblers, as a result of feeling inadequate that led to the creation of a fantasy world in which gambling is seen as a solution. This creates a narcissistic illusion of power. These defense mechanisms of omnipotence, splitting, idealisation and devaluation, projection and denial are seen as defences against helplessness and other intolerable feelings. These considered defences are worked through in the therapeutic encounter. Within psychodynamic theory, problems in parental identification are also seen to lead to gambling (Boyd & Bolen, 1970; Weissman, 1963). Limitations of psychoanalytic theory include its lack of empirical evidence and predictive power as well as the fact that little data has demonstrated the effectiveness of psychodynamic psychotherapy in PG. Most research conducted has been on single case studies (Ferris, Wynne & Single, 1998). Though a set number of sessions have not been recommended, longer term therapy to address defensive functions are viewed as more effective (Boyd & Bolen, 1970). This may be seen as more difficult to achieve in our current context of therapy delivery for PG, which is favoured by shorter term CBT. The processes of psychodynamic psychotherapy that make a difference have also been deemed as being difficult to understand (Rosenthal, 2008) and has been criticised as being more theoretical than scientific as the unconscious and psyche are unmeasurable (Ferris et al., 1998).

However, the psychodynamic models contribution should be considered seriously as it allows practitioners to understand internal, unseen processes in addition to dealing with the presenting gambling difficulties. This approach

may benefit problem gamblers who have histories of loss and grief, relationship issues and the "drive to create the fantasy of importance, respect, power and control that is often central to the gambling experience" (Upfold, 2017, p.5). The process of therapy and tackling the restriction of gambling behaviours may bring these unconscious conflicts into awareness and cause tension during the therapeutic process. Therapy processes may have a role in addressing deeper mechanisms which other modalities such as CBT do not address and elaborate conjecture (Ferris et al., 1998). The importance of addressing subconscious conflicts and whether these issues need to be sought in early PG are in contention (Fong, 2005). The following section looks at cognitive behavioural models of gambling.

1.4.5 Cognitive Behavioural Theories

Behavioural frameworks are underpinned by Social Learning Theory (Bandura, 1977), which posits that observational learning and modeling play an influential role on a person's behaviour. It has been suggested that modeling may have a strong learning component in the acquisition and maintenance of gambling behaviours, and social influences such as peers may be involved in enabling gambling behaviour in youths (Hardoon & Deverensky, 2001).

Gambling behaviour can be viewed as a learned behaviour reinforced by stimuli in a gambling environment, such as lighting, spinning wheels, or hypnotic music. This reinforcement is proposed to contribute to autonomic arousal and the individual's experience of excitement. Pleasurable experiences are sought through these learned responses and rewards. Sharpe and Tarrier (1993) assert that gambling is maintained by the winning and losing of money with a variable internal schedule of reinforcement, which can be explained by both operant and classical conditioning. This behaviour can be seen in problem gamblers when individuals experience urges in response to stimuli, often leading to relapse. Gambling can persist despite losses as individuals learn that wins can be intermittent, and that persistence may lead to more wins (Griffiths, 1995). The cognitive-behavioural model is borne from social learning theory and combines the concept of behaviour initiation, with cognition (attention, interpretation and conclusions drawn about events that go on around them) (Upfold, 2017). Cognitions[1] are thought to foster gambling persistence by unrealistic or irrational thinking (Sharpe & Tarrier, 1993). Those who misinterpret the causes of wins and losses may develop a belief system that they will be successful and therefore become more successful at gambling. Cognitive behavioural theories have come under fire for ignoring early traumatic life experiences and failing to account for subjective experiences and by emphasising observable behaviour (Beidel & Turner, 1986). However, this main perspective has created the body of Cognitive Behavioural Therapy (CBT) that is seen in services today (see next section). Therapy highlights the role that conditioning principles play in the maintenance of PG and emphasises the impact of individuals' cognition on their behaviours. During therapy, strategies are learnt to stabilise excessive gambling and, following this, techniques are offered to help cope with urges to gamble and minimise harm in the event of a lapse.

1.4.6 Integration of Models

The above summary of theory highlights the complex and multifaceted nature of gambling, and it has been suggested that a more integrated approach taking into account various theoretical perspectives may overcome individual limitations and provide a more cohesive account of gambling struggles (Griffiths, 2005). Blaszczynski and Nower's Pathways Model (2002) attempts to take into account multidimensional social and biological components and identifies three main subgroups of problem gamblers: Pathway 1: the 'Behaviourally Conditioned' subset lack pre-morbid features of psychopathology and high levels of depression may occur as a result of problematic gambling behaviour; Pathway 2: the 'Emotionally Vulnerable' commonly present with pre-morbid instances of depression and a history of poor coping and/or negative childhood experiences. For this subset, gambling may be a strategy for emotional regulation; Pathway 3: the 'Anti-Social, Impulsivist' subset of individuals are likely to have biological and psychosocial vulnerabilities, resulting in the display of multiple maladaptive behaviours and impulsivities such as suicidality, criminality and substance misuse. The pathways model was created following the conclusion that imposing one theoretical model to all pathological gamblers is misguided, and that various variables can have differing levels of influence on a problem gamblers aetiology and therefore has implications on the appropriateness of interventions.

1.5 Psychological Interventions for PG

The following section reviews current therapy provided for PG in the UK. Cognitive Behavioural Therapy has provided the most evidence for successful therapy for PG (Petry et al., 2006; Sylvain, Ladouceur, & Boisvert, 1997). Cognitive-behavioural approaches focus on correcting erroneous cognitions about randomness, false assumptions and biased information processing, in addition to physical and psychological responses related to gambling (Bowden-Jones & Clark, 2011; Cowlishaw et al., 2012; Ladouceur et al., 2003; Toneatto, 1999). This is achieved using cognitive restructuring, analysis of triggers and risk, stimulus control, social skills training, relapse prevention and relaxation (Dowling, Jackson, & Thomas, 2008; Gooding & Tarrier, 2009; Sylvain, Ladouceur, & Boisvert, 1997).

Apart from CBT, self-help (e.g. Gamblers Anonymous), family therapy, psychodynamic therapy and pharmacological therapy (e.g. Naltrexone) are currently being used in the treatment of PG (Griffiths, 2005; Petry, 2006). Though CBT has been researched to a greater extent, few other interventional outcome studies have challenged this. A review has found that those outcome studies that do exist lack clear conceptualisation of the model being investigated as well as outcome measures. They often do not report compliance and attrition rates and have short follow up periods. (National Research Council, 1999).

Therefore, a single treatment has not yet been sufficiently demonstrated as superior to any other (Weinstock et al., 2008), and the long-lasting effects of CBT and other psychological therapies have been little researched (Cowlishaw et al., 2012). The National Institute for Health and Care Excellence (NICE) does not yet offer guidelines of best practice for therapy for PG, indicating the uncertainty of its treatment over the years. PG does not necessarily fit a typically persistent and chronic downward trajectory, but often moves in and out with frequent relapses and recovery can occur naturally without treatment (Slutske, 2006). There is a need to be aware of this fluctuating state of PG and the need for treatment service input at different stages whilst monitoring gambling habits.

1.6 PG prevalence in Ethnic Minority Populations

Gambling activities are present in almost every culture (Raylu & Oei, 2002). The following section will explore prevalence rates of gambling in various Western communities before examining factors relating to PG in ethnic minority groups. Blaszczynski, Huynh, Dumlao, & Farrell (1998) explored PG rates within a metropolitan Chinese community in Australia. They found a prevalence estimate of 2.9 percent for PG with males showing a higher rate (4.3 percent) than females (1.6 percent). This rate was almost three times greater than the 1.2 percent reported for the Australian population (Dickerson, Baron, Hong, & Cottrell, 1996), a rate similar to those found in other studies looking at the prevalence of PG among the Chinese community in several countries, which has been seen to exacerbate challenges of immigration such as cultural and linguistic adaptations (Chan, 2000). In a similar finding, 19.5% of South East (SE) Asians gambled, of which more than one third were classed as PG (7.9%), reflecting the UK statistics (Park et al., 2010). Ethnic minorities have been found to be more likely to be economically disadvantaged. A review of National UK statistics found that all minority groups had higher rates of poverty and deprivation than the rest of the population (Platt, 2007). Among the highest are Bangladeshis, Pakistanis, and back Africans, whilst rates were still high for Indian and Chinese households.

Chinese immigrant problem gamblers in NZ reported no easy access in their homeland and no history of gambling problems, implying that an increased accessibility in the host country may have led to the development of PG (Wong & Tse, 2003). However, this rather simplistic view does not take into account the complex set of variables that may also contribute to this development i.e. adapting to a new country or socioeconomic status. Kim (2012) published a review of gambling behaviours in SE Asian North Americans and Australians and found that although the prevalence of gambling in the Asian population was lower, the rate of PG as defined by the DSM-V was higher than or equal to the general population of the US. The review had not clearly stated the inclusion criteria of studies and differing gambling activities were considered together. The author concluded that a gambling-permissive SE Asian culture coupled with the greater availability of gambling may have contributed to an increase in gambling participation in SE Asians living in the US and other Western countries (Kim, 2012). This echoes the findings of the UK prevalence

surveys which illustrate that ethnic minorities are at increased risk of becoming problem gamblers, despite displaying gambling behaviours at the same rate of the general population. Kim's review, however, fails to acknowledge the multifaceted personal issues that may face this population and reduces the behaviours as caused by objective differences such as accessibility and a permissive overarching culture. This creates a complex issue of addictive gambling behaviour intertwined with cultural adaptation issues that immigrants may face. Increased opportunities and legalised gambling may lead to disproportionate effects in vulnerable populations, such as racial minorities and economically disadvantaged people (Alegria et al., 2009; Volberg, Nysse-Carris, & Gerstein, 2006). The following chapters will further explore variables that may play a role in the development and exacerbation of PG in ethnic minorities.

Culture and ethnicity[2] have been found to be key variables in understanding the prevalence of PG (Petry, Stinson, & Grant, 2005; Shaffer, Hall, & Bilt, 1999). Research on ethnic minority populations have consistently shown higher rates of PG behaviour compared to their Western counterparts akin to the UK prevalence surveys. Studies have found high prevalence rates of PG among Native Americans (Cozzetto & Larocque, 1996; Peacock, Day & Peacock, 1999; Zitzow, 1996), indigenous participants in North Dakota (Volberg & Abbott, 1997), Asian university students in the United States (US) (Lesieur & Rosenthal, 1991; Raylu & Oei, 2004), indigenous groups in New Zealand (NZ), Aboriginal populations in Canada and Australia (Dickerson, Baron, Hong, & Cottrell, 1996; Wardman, el-Guebaly, & Hodgins, 2001; Williams, Belanger & Prusak, 2016), a Chinese community in Australia (Oei, Lin, & Raylu, 2008) to name some. These results display higher prevalence rates in minority populations, which indicate that these communities may be at a higher risk of developing gambling problems than native Western populatios. Ethnic minorities have been found to spend more money when gambling (Welte et al., 2001) even though they have been found to gamble at a lower or similar rate to the general population. As Tse et al.'s (2012) study illustrates, there are differences in the meaning of gambling amongst different cultures. An increasing trend of gambling availability and lack of a limit of spending in venues can potentially result in heightened gambling activity and expenditure. Furthermore, labelling gambling as a disorder may reduce the probability of people seeking services by people from cultures with highly permissive beliefs towards gambling (Okuda, Balán, Petry, Oquend & Blanco 2009), possibly

[2] Literature has often used the terms 'ethnicity' and 'culture' interchangeably. The words originally described in the published papers will be used, and so the concepts will be used interchangeably here too. Ethnic groups have been referred to as people who share language, customs and common ancestry (Bulmer, 1996). Members build their lives with respect to this, from which they give substance to their minds, wills, and directed actions (Raylu & Oei, 2004). Culture is described as a dynamic system of implicit and explicit rules. Established by groups, the aim is to ensure survival and to maintain attitudes, values and beliefs (Matsumoto, 2007). It is important to note that in the UK, SA is commonly defined as having an ethnic background from one of the following countries: India, Pakistan, Bangladesh and Sri Lanka (NHS Choices, 2014).

leading to greater rates of PG. As seen above, Chinese immigrants who gambled in their homeland before moving to a Western country have been found to be associated with PG in their new host country (Blaszczynski et al., 1998). Rates of PG are also much lower in ethnic minorities before moving to their Western host country (Fong & Ozorio, 2005; Park et al., 2010) and immigrants have reported no previous PG (Wong & Tse, 2003). This suggests a public health concern and a need for awareness of a host country that may not be equipped to tackle the potential harm that gambling facilities may be exerting on immigrants, who may already be at an increased risk of the above variables.

1.7 Factors Affecting PG in Ethnic Minorities

Significant factors including familial, sociological, and individual characteristics have been implicated in the Western gambling literature as playing important roles in the development and maintenance of PG. These include irrational cognitions, age, biological or genetic traits of impulsivity, vulnerable psychological states such as stress, and socioeconomic factors such as unemployment, being widowed, divorced or area of residence (Petry, Stinson, & Grant, 2005; Raylu & Oei, 2004; Shaffer, Hall, & Bilt, 1999; Volberg, 2003). Consequently, those variables that are considered by the author as most relevant to ethnic minorities will be explored in the following section.

1.7.1 Acculturation Stress

Acculturation occurs when cultural groups and members come into contact with a dual process of cultural and psychological change (Berry, 2005). Individual aspects of self-identity, such as behaviours and values adapt to adjust to the mainstream culture (Ryder, Alden & Paulhus, 2000). Acculturation stress can occur as a result of unique hardships related to the minority status, and from boredom, isolation and loneliness in immigrants, which is often associated with increased gambling motivation amongst problem gamblers (Abbott & Volberg, 2000; Blaszcynski & Nower, 2002; Caler, Garcia & Nower, 2017; Raylu & Oei, 2004). Research looking at acculturation will be explored in this section.

Qualitative research has explored acculturative experiences of immigrants gambling in Western countries. A comparative case study design interviewed four Chinese Canadian problem gamblers who experienced difficulties during migration such as insecurity and disconnection from family and friends (Lee, Solowoniuk & Fong, 2007). The study aimed to develop a framework to understand why people begin and continue gambling. Coupled with a limited experience of legalised casino gambling in their own country, gambling became a form of escape from acculturation stresses and adaptation problems. Additionally, findings related to the specific interview questions targeted at pre-immigration trauma history. The themes collated suggested that pre-immigration trauma (‘loss and

abandonment', 'neglect and deprivation', 'physical, emotional and psychological abuse', and 'socio-political oppression') may have contributed to the development of PG.

Tse et al. (2012) examined how environmental, cultural and social factors interact with personal characteristics, and influence gambling behaviours. They conducted a qualitative study of 131 people from four ethnic NZ groups (Maori, Pacific, Pakeha/NZ European and SE Asian) which explored the meaning of gambling. Social and problem gamblers, families of problem gamblers and professionals were qualitatively interviewed. Data was analysed using an inductive approach. The study found that Europeans gambled to win and recoup losses. By contrast, Maoris gambled for relaxation and rest from the stress of belonging to a large family. Pacific Islanders gambled when bored due to unemployment or when stressed from financial difficulties. Chinese participants gambled to regain status as well as to win, and used it as an escape mechanism from depressing realities of their lives. Furthermore, Chinese immigration and post immigration adjustment issues were themes found to have contributed to gambling behaviour i.e. relationship difficulties, communication problems, boredom, frustration, under or unemployment, the absence of places to socialise and express themselves, and escape from depressive feelings/tough situations. In NZ, when compared to white European groups, ethnic groups appeared to have had additional difficulties many of which may be related to their cultural differences. For some, gambling was illegal in their home countries and the novel legal status encouraged them to try it when they arrived in NZ. For those who wished to isolate themselves; gambling replaced relationships with people. This study outlines how the environment may introduce behavioural gambling change in immigrants who were otherwise unaware of the possibilities of gambling in their host country. Although this study highlighted the importance of ethnicity and culture in gambling, the scope was broad, including both genders and four different ethnic groups. There was a lack of specificity within the analysis surrounding each group. The interviews did not appear to go deeper into the meaning and understanding of PG for each participant and did not address the interrelationships of culture in relation to their gambling.

Following a systematic review of the role of culture in gambling, Raylu & Oei (2004) offered reasons why there may be globally elevated rates of gambling amongst indigenous and immigrant populations in Western communities. These included an increased availability and change in the meaning of gambling when people move. They also suggest that cultures which endorse and accept gambling tend to have higher rates of gambling i.e. due to the legitimacy of making quick, easy money. Other reasons mentioned were using gambling as a coping mechanism to adapt to a new culture, and as a successful acculturation process ironically to try and integrate into mainstream culture. It is therefore suggested that immigrants who experience adjustment difficulties such as acculturation might be more susceptible to gambling problems.

1.7.2 Acculturation and Identity in Second Generation Children

A link has been found between parents adopting a *separation* acculturation style and an increase in psychological problems in second-generation children (Anwar, 1998; Koplow & Messenger, 1990; Minde & Minde, 1976; Shaw, 2000), whereas *integration* has been shown to increase psychological health (LaFromboise, Coleman & Garton, 1993). Four case studies of young children whose parents recently immigrated revealed a failure in the children to integrate cognition with feeling, which became a cultural bridge at the expense of acquiring individuation (Koplow & Messenger, 1990). Segal (1991) suggests that Indian self-identity is defined by the family, and therefore becomes an added challenge for children creating their own self-identity based on conflicting cultural allegiances and may be at risk of alienating themselves from peers or from their own community and family (Farver, Bhadha & Narang, 2002). This is likely to be followed by assimilation with the external culture to fit in with peers and creates a dissonant acculturation style (Portes & Rumbaut, 1996) whereby children learn new values in school whilst parental values become less intact.

American-born Indian adolescents have been shown to exhibit internalised problems reflecting conflicts or prejudice and discrimination experiences that are likely to affect self-esteem, whilst increased self-esteem is associated with adopting the host culture customs, as well as contributing to better school outcomes (Ghuman, 1999; 2002). Further to this, a qualitative study of Asians in Britain found that second-generations preferred to adopt a bi-cultural or hyphenated identity (Modood, Beishon & Virdee, 1994). In this study, 49 young SAs were interviewed face-to-face to explore their sense of the notion of 'Britishness.' More than half of the respondents felt British but wanted to retain an amalgam of the core heritage alongside this as a wish to live in an ethnically mixed way. They also did not feel fully accepted by the white British who they perceived were reluctant to accept their cultural differences; a perceived racial prejudice resulting in them feeling pressured to minimise their ethnic identity. Lalonde and Giguère (2008) similarly conducted a qualitative study of first and second-generation young biculturates who wished to hold onto their ethnic heritage but for it not to mean social segregation. They also describe related conflicts potentially faced by second-generation individuals, creating disharmony with a Western culture which emphasises the importance of individual autonomy which may create a sense of isolation, hopelessness, lack of belonging, and undermine their sense of 'self' and their upbringing as a SA male.

A similar finding was also found in qualitative interviews with second-generation Pakistani and Indian females, which revealed the impact of being frequently reminded of their ethnic difference from family and peers, making it difficult to blend in and move away from being viewed as a racialised subject (Rajiva, 2006). The awareness of their ethnic difference is reduced in Indian adolescents in India, illustrating the probability that Indian females may feel part of a minority group in British society (Stopes-Roe & Cochrane, 1990). This awareness of ethnic difference has previously been described as a salience of ethnic consciousness (Hutnick, 1991) and may illustrate the ongoing

difficulties with identity SAs face when negotiating a culture different than that of their parents, and the difficulty it causes in creating an identity different to theirs.

Phinney's (1990) review found that the more one identifies with their ethnicity, the higher their self-esteem. This finding conflicts with studies that have found high self-esteem to be associated with an integrated acculturation style (see LaFromboise, Coleman & Garton, 1993, for a literature review). Perhaps the decision to make a stronger allegiance with their ethnicity suggests that the individual is happy with the dissonance and has made a choice to identify with their parents, which may be associated with higher self-esteem. Lower self-esteem may be associated with those who feel the pressures and uncertainty of their allegiance and who are conflicted in making this life-choice. The relationships between issues with self-esteem, acculturation and parental allegiance illustrate the complexities of identity formation and cultural differences in relation to young and second-generation immigrants.

Conflicts concerning the grappling of two cultures and overall stress of adaptation may heighten the risk of problematic behaviours such as gambling (Harris, 1999) as second-generation or children of immigrants have been found to be more likely to engage in risky behaviours (Camarota & Vaughan, 2009). Atzaba-Poria & Pike (2007) concluded that a child parent acculturation misalignment is a risk factor for Indian adolescent problem behaviour, when exposed to two cultures with conflicting demands, particularly between individual and collectivistic dimensions. This leaves second-generation SAs with the potentially difficult task of forging their own identity whilst becoming involved in the pressures of the host and parental cultures (Dhillon & Ubhi, 2003), which may lead to psychological difficulties. A recent analysis of worldwide data of up to 35,000 people found that second and third-generation immigrants and non-immigrants were significantly more likely to develop PG compared to first-generation immigrants and native-born Americans (Wilson, Salas-Wright, Vaughn, & Maynard, 2015). Furthermore those who arrived in the US as children gambled more frequently. The authors suggest that this may be due to an immigrant paradox (a protective factor whereby despite immigrants being socially disadvantaged, they are less likely to engage in problem behaviours) which has been found in other problem behaviours such as crime and violence (Zatz & Smith, 2012). Findings suggest that subsequent generations are at increased risk of PG. This increased risk may be due to additional variables explored in this chapter.

Sobrun-Maharaj, Rossen and Wong (2013) used focus groups and individual interviews to study 144 problem gamblers in Asian ethnic groups in NZ (including 27 SAs). It was found that people used gambling as a coping mechanism, and subsequently encountered mental health, social and financial difficulties. Unfortunately, the results were not grouped by ethnicity meaning we cannot ascertain unique difficulties faced by SAs. The cohort also contained a mixture of generations. Whilst first-generation immigrants may experience adjustment and language difficulties, second-generation immigrants face conflicting pressures of having to appease their family's traditional

Eastern values whilst simultaneously having to fit in with the Western way of life. This is illustrated by Dhillon and Ubhi's (2003) qualitative study which found that, as a result of this conflict, second-generation SAs in the UK are put under considerable pressure as they feel unable to affiliate completely to their own and the host culture. This resulted in the participants not feeling British, Indian or Pakistani, thus making it difficult to negotiate these identities.

1.7.3 Shame, Guilt and Blame

Shame and guilt are both internal experiences of self-blame. Shame involves negative evaluations of the self and guilt focuses on being critical of the behaviour (Tangney, Stuewig & Mashek, 2007). Shame and embarrassment, pride and denial have been found to be barriers to treatment for PG (Hodgins & el-Guebaly, 2000; Pulford et al., 2009) where physical appearance largely remains undamaged, making it easier to conceal (Donaldson, Langham, Best, & Browne, 2015; Horch & Hodgins, 2008).

Attributions of blame to the individual rather than the disease can be enhanced in PG as a medical rationale does not hold up compared to substance addiction (Dunn, Delfabbro & Harvey, 2012). Indirect self-stigma was increased with expectations that others apply negative stereotypes, such as demeaning and discriminatory ones towards them (Hing & Russell, 2017), and has been found to be the case for problem gamblers in qualitative enquiry (Corrigan, 2004). It also occurs when individuals internalise these stigmatising attitudes (Corrigan & Rao, 2012) and believe them to be true and attach corresponding stereotypes to one's self. This may leave people feeling at fault due to weakness and lack of self-control (Carroll, Rodgers, Davidson & Sims, 2013; Hing, Russell, Gainsbury & Blaszczynski, 2015; Horch & Hodgins, 2008). Hiding shameful problems to protect oneself and manage their identity from being shunned by others, including cultural communities, may explain the avoidance of seeking help (Carroll et al., 2013; Hing et al., 2015), until the point of desperation (Evans & Delfabbro, 2005; Hing, Holdsworth, Tiyce & Breen, 2014; Suurvali, Cordingley, Hodgins & Cunningham, 2009). Anticipated stigma has previously been associated with worse psychological wellbeing, particularly for concealable conditions (Quinn & Chaudoir, 2009) such as gambling. This may be particularly damaging in collectivist cultures. East Asians had an increased stigma towards PG behaviours compared to Caucasian Canadians (Dhillon, Horch, & Hodgins, 2011). Those who endorse negative stereotypes towards others are less likely to acknowledge their own need for help to protect self-esteem (Perlick, Manning, Grant, & Potenza, 2007). In Australia, the Chinese community were able to recognise other problem gamblers but failed to admit the extent of their own problem (Blaszczynski, et al., 1998). Not recognising the problem was widely reported as a sense of denial in Chinese, Greek and Vietnamese communities in Australia (Scull & Woolcock, 2005). Damaging effects include withdrawal from social support and avoidance of help-seeking, meaning limited chances for recovery (Carroll et al., 2013; Hing, Nuske, Gainsbury, Russell & Breen, 2016; Vogel, Wade & Hackler, 2007).

1.7.4 Help-Seeking and Stigma

It has been posited that culture provides the framework through which individuals attribute meaning to gambling and shape subsequent risk management, which is passed down generations (Raylu & Oei, 2004). One variable that contributes significantly includes attitudes towards seeking professional help, uncommon in collectivist cultures due to high reliance on self-help and support from the community. As much as 82% of those with gambling problems do not seek therapy (Slutske, Blaszynski & Martin, 2009). Collectivist cultures are also likely to hide problems due to feelings of shame and stigma or fear of losing respect from their family and community (Loo et al., 2005; Scull & Woolcock, 2005). Other reasons not to seek help have been embarrassment and pride, a wish to handle the problem on their own, or to avoid stigma (Duong & Ohtsuka, 1999; Goodyear-Smith et al., 2006; Hodgins & el-Guebaly, 2000). Such behaviours will be explored further in this section where the complexities and the intertwined nature of the variables will be presented.

In many SA communities, a governing concept 'izzat,' meaning honour in Urdu and Persian, may determine communities' wish to handle problems by themselves for fear of being shamed, stigmatised or embarrassed (Khan, Shabir & Ahmed, 1995). As a result, there is an unwillingness to admit to problems in the community, leading to difficulties in help-seeking. A study looking at SA substance misusers in the UK suggests that any potential damage to a family's izzat is felt by identifying a member as a substance user (Wanigaratne, Dar, Abdulrahim, & Strang, 2003). This may create difficulties in detecting problems in the community as low levels of drug abuse reporting have been found in SA groups in the UK (Pearson & Patel, 1998). A number of barriers to SAs help-seeking for drug use were observed in Wanigaratne et al.'s (2003) study. These were a perception of staff's lack of understanding and empathy, fears about confidentiality and the consequence of having drug user status revealed as a result of receiving external help. Shame and stigma have previously been identified in studies on SAs accessing mental health services (Das & Kemp, 1997), but little has been conducted on addiction, and PG. A similar trend of disproportionate high prevalence of mental health issues is shown (Weich et al., 2004) as well as low participation rates in SA mental health trials (Hurrel & Waheed, 2013). Studies have found that British SAs can be reluctant in seeking help and going to therapy for their mental health issues, which may be as a result of culturally determined beliefs (Sheik & Furnham, 2000). Varying manifestations of PG in different ethnic populations illustrate the role cultural beliefs can play in the aetiology of this problem. In some cultures, a reluctance to seek help can be directly related to the fact that the family is traditionally the only source of help and support as opposed to an outside agency (Duong & Ohtsuka, 1999).

Non-gamblers and social gamblers were shown to have higher mean scores on family support (Hardoon, Gupta & Deverensky, 2007). Decreased levels of social support are linked to therapy drop-out of PG (Melville, Casey & Kavanagh, 2007), whilst family involvement enhances treatment seeking, completion and better outcomes. A study

which found that first-generation adolescent immigrants were twice as likely as non-immigrant peers to be at risk of PG, particularly when living apart from parents (Canale et al., 2017) further suggests that a lack of familial support may be a contributing factor for PG. Other protective factors enabled by culture include increased parental monitoring within social and family activity, which resulted in less health risk behaviours (Stevens et al., 2015). In Raylu and Oei's (2004) review on SE Asians, problem gamblers were less likely to seek help as services were seen as under resourced or due to the shame associated with it. Limiting self-disclosure may avert humiliation from the family (Tse, Wong & Kim, 2004). It may be possible that these issues play a role in SAs' help-seeking, and these may need to be explored in greater depth in future research. It could be suggested that work needs to be conducted to understand their experiences of therapy in order to ascertain that the help they receive is satisfactory for their needs. Thus, the importance of learning about cultures to provide appropriate and efficacious services have been established (Miranda et al., 2005). Looking for understanding into vulnerable populations in any context, potentially marginalised by a lack of services, is important.

Amongst those relatively few problem gamblers who attend therapy, a high proportion prematurely discontinue (Grant, Kim & Kuskowski, 2004). This can be up to fifty percent (Melville et al., 2007; Smith et al., 2010). Difficulties in formation of the therapeutic alliance may be associated with non-compliance (Dunn, Morrison & Bentall 2006) and withdrawal from therapy may be preferable to 'failing' (Dunn et al., 2012; Petry, Stinson, & Grant, 2005). This emphasises the importance of understanding the experiences of those who enter therapy, yet little work has been conducted with subgroups of PG (Khanbhai, Smith, & Battersby, 2017). It has been found that 97% of UK Trusts do not provide a service to treat problem gamblers (Rigbye & Griffiths, 2011) and most current provision is by the third sector. Such findings illustrate the challenges for CPs and service providers and the need for more resources. A more coordinated approach between professionals working with problem gamblers may be most helpful.

1.7.5 Gender Roles and Problem Gambling

Males have regularly been found to have greater rates of PG (Petry, Stinson, & Grant, 2005; Shaffer, Hall & Bilt, 1999). This may be due to cultural gender roles whereby pressure is placed on the man to provide for the family (Kramer, Kwong, Lee, & Chung, 2002), and thus has control of the household money, leaving women at a lesser risk. Within traditional societies such as India, different expectations exist between males and females i.e. males are generally permitted to have more autonomy, independence and educational opportunities (Ghuman, 1991), which may influence their acculturation preferences and adaptation to the host culture (Farver, Bhadha & Narang, 2002).

Differences have also been found in gambling habits; women have been found to typically begin gambling later in life and on a narrower range of activities and problems develop more quickly, whereas gambling problems in men extend back to adolescence (Merkouris et al., 2016; Toneatto & Wang, 2009). These may stem from different life experiences and may differ further in different cultures. Gender differences for PG have also been found in barriers to help-seeking i.e. for men, admittance and emotional responses and vulnerability to gambling as perceived from others were stigma-related barriers, whereas for women, being seduced by the 'bells and whistles' (Baxter, Salmon, Dufresne, Carasco-Lee & Matheson, 2016, p.6) of gambling venues, denial of addiction, belief in luck and casinos and shame of being dishonest were barriers (Rockloff & Schofield, 2004).

SA men are under-represented in research into psychological therapies (Bhui & Bhugra, 2002; Mahr, McLachlan, Friedberg, Mahr, & Pearl, 2015; Rathod, Naeem & Kingdon, 2013), and the psychological needs of this population in gambling services remain unexplored. Moreover, research has primarily focused on SA women and their views and experiences of therapy (Anand & Cochrane, 2005; Khan & Waheed, 2009), whilst little consideration has been given to SA men. It is therefore important to explore the idiosyncrasies of men in relation to their gambling experiences.

1.7.6 The Political Climate and Religion in South Asia

Political histories for SAs may be different. In India, for example, there is a formal ban on most forms of gambling, which has created an illegal market (Benegal, 2013). There have been high profile oppositions to gambling on a national scale i.e. cricket match fixing (Times of India, 2010). It is seen as a popular pastime, and a ubiquitous part of daily life for centuries (Benegal, 2013), and popular during religious festivals. Concern for the consequences from PG is underestimated in public discourse (which focuses on moral values) and academia, and few are sensitive to the notion it can become a psychiatric issue (Sinha, 2011). Gambling treatment does not occupy a place in mainstream psychiatry in India, perhaps highlighting the lack of training in this field i.e. a study carried out in South India found that 84.2% of psychiatrists had never been trained in gambling addiction (George, Kallivayalil, & Jaisoorya, 2014). Therefore, migrants from SA could be at risk of PG due to the unfamiliarity of psychological help, availability and stigma stemming from their country's dismissal of it.

Research highlights the influence of values and beliefs inherent in specific cultural groups (Alegria et al., 2009; Raylu & Oei, 2004; Sacco, Torres, Cunningham-Williams, Woods & Unick, 2011). For example, the dominant cultural norm in China is Zhang Yong or 'doctrine of the mean,' which encourages the avoidance of extremes when presented with opposing views. This enables conflict resolution and harmonious relationships (Cheung et. al., 2006). Gambling is an acceptable social activity and part of the lifestyle and tradition (Clark, King & Laylim, 1990; Raylu

& Oei, 2004). Their values enhance illusion of control (Oei & Raylu, 2008) which may lead to riskier gambling choices and reluctance in help-seeking due to the attribution of failure (Loo, Raylu & Oei, 2008). Anecdotally, it has been found that Chinese gamblers more often 'test their luck' compared to British gamblers and depend more upon perceived luck than the possibility of outcomes (Walker et al., 2006). Cross-cultural differences in University gambling cognitions found that Chinese have a greater tendency to fall susceptible to gambler's fallacy than European Canadians. This may result in gambling for longer and betting higher stakes, which may account for the high numbers of PG in Chinese problem gamblers. This indicates that cultural variables may play an important role in gambling cognitions (Raylu & Oei, 2004). It is important to recognise the importance of different cultural concepts which can govern societal norms, and how this may influence risk-taking behaviours (Park, Kim & Zhang, 2016), such as gambling in their natal and host countries.

Religion can provide different meanings upon immigration. A survey in the US not only found that SA immigrants maintain their religious practices and customs when in their host countries but in fact increased their religious participation than when living in their native society (Williams, 1988). The behaviour of increased religious participation indicates its importance in the process of adjustment to a new country and may be an attempt to reinforce their ethnicity and bind their community whilst focussing their traditions and heritage onto younger generations (Dasgupta, 1998; Sheth, 1995; Williams, 1988). Religion can also impact the way people acculturate to a host culture. reference In second-generation SAs, ethnic values such as religion have been considered as lower in importance (Ali & Aboul-Fotouh, 2012). Hindus and Sikhs were found to be higher on the bicultural scale and more assimilated than Muslims (Ghuman, 1999; Stopes-Roe & Cochrane, 1990), and Islam has been found to be important in how second-generation Muslims live their lives (Modood et al., 1997). It has previously been shown that a match between personal and family acculturation has implications for higher psychological functioning (Asvat & Malcarne, 2008) and religiosity has been found to serve as a protective factor in PG (Welte, Barnes, Tidwell & Wieczorek, 2017). SAs who differ from their extended traditional cultural beliefs and values (including religion) may be at increased risk of mental health problems (Sonuga-Barke & Mistry, 2000). Countries under Islamic Syari'ah law where gambling is illegal for Muslims could have further impacts on the perception of gambling and motivation to take part. In Malaysia, gambling is illegal for the wider population without a granted permit or license (Loo & Phua, 2016), but illegal gambling activity is still rife. Singapore is another multi-ethnic country which provides cultural contrasts in gambling. Prevalence rates in Singapore are decreasing (now 0.2%) due to effective regulation and safeguards in place after recognising the problematic nature of gambling (Winslow, Cheok & Subramaniam, 2015). This may impact the risk behaviours of Singaporean immigrants. For Native Americans, structural concepts of fate and reliance on magical thinking may encourage gambling and have been found to be more likely to be at risk of PG compared to non-Native American counterparts (Binde, 2007; Zitzow, 1996). The authors concluded that the cultural

acceptance of magical thinking may allow such beliefs to be generalised to gambling to try one's luck or belief in fate.

From the above review, it could be concluded that there is potentially an interaction of many factors contributing to the ethnic minority populations being at increased risk of undertaking gambling behaviours. Such interacting variables can be minority ethnic status, stress of a new culture, or being between two different cultures, alienation, discrimination, and socioeconomic circumstances. It is impossible to find a true cause of this, but the above variables may all predispose, in varying degrees, to someone taking up gambling. The above variables may be contributed to by the ethnic minorities' values and beliefs. To date, few qualitative enquiries have been conducted on immigrant populations. PG and culture research has mainly focussed on immigrant Chinese and other SE Asian communities.

Despite evidence showing high rates of PG among different cultural groups and the adverse consequences associated with this, this trend is not mirrored in the underrepresented number of ethnic minorities attending PG services (Braun et al., 2014: Raylu & Oei, 2002; Wong & Tse, 2003). Evidence shows us that only a small percentage of problem gamblers seek help, implying that an even smaller proportion of these are likely to be ethnic minorities. It therefore becomes difficult to understand the gambling behaviours of SAs for PG in the UK due to a lack of research. There are studies, however, that have looked at the issue of PG in SE Asians. The experiences of ten recovering Malaysian male problem gamblers enrolled in a recovery programme in NZ were examined using a phenomenological reduction technique (Choong, Loo & Ng, 2014). Gambling was associated with enjoyment and excitement, and a desire to acquire recognition and respect from family and friends. Financial gains were linked to the gambler's self-esteem as well as representing an increase in positive self-perception of social status amongst significant others. Satisfied participants were those who spent their own money and were able to maintain a role of a good father or husband and provide for their family. Conversely, participants viewed themselves negatively or as selfish when they borrowed money and when in debt. Disappointing family members left them with a sense of hopelessness. Many participants reported abstaining from gambling in order to appease family members. Some took the decision to quit after their family no longer offered assistance for debts and when relations ties were severed, they felt guilt towards their family or their family ceased communication. Interestingly family support played a fundamental role once participants had joined the recovery programme. This study adds to the finding that families can have a powerful impact on a SE Asian problem gambler. What it does not show us are the experiences of their culture in relation to PG, not just the familial role, which is a part of the culture. This does not appear to have been explicitly explored.

In a community based qualitative pilot study looking at non-English speaking communities in Australia (Chinese, Greek and Vietnamese), motivation and impact of PG were explored. Eight in-depth qualitative interviews were conducted with problem gamblers and relatives. Similar themes were the lack of knowledge about PG and the

reluctance to discuss their PG. Gambling was associated with shame and stigma for the entire family (Scull & Woolcock, 2005). As a result, most problem gamblers did not seek professional help, but tried to resolve the problem themselves or within the family unit, a finding which has been found elsewhere (Fong & Tsuang, 2007). The authors found that denial was experienced due to the possible shame that would be linked to their family. Immigration processes and settlement difficulties were found to lead to increased pressure and isolation, whilst extended families were overseas. Additionally, as gambling culture may change in the host country, vulnerability is cultivated. This study presents a case that cultural issues i.e. extreme stigmatisation of gambling in immigrants serves to promote social marginalisation and family disapproval may, in turn; inhibit the urge to access treatment. On top of the disinclination to seek help, participants experienced increased pressures to achieve after migration. Those who seek help may only do so once their issues become intolerable. Though it provides greater insight into cultural aspects in PG, participants in this study were analysed generically as ethnic minorities and culture was not explored as a direct question in the interviews. There was also a mix of genders, and participants were non-English speaking, first-generation immigrants. Therefore it is important to appreciate the nuances of different cultures rather than research taken as a whole in contrast to Western cultures, making the results non-generalisable to particular cultures. This study aims to explore a more homogeneous sample focussing on male, English speaking, second-generation SAs who are at increased risk in the UK context of becoming problem gamblers.

1.8 Culture and Therapy

CBT and other psychotherapies have initially been established based on Western cultural references and individualistic values (Benish, Quintana & Wampold, 2011; Franklin, Carter & Grace, 1993; Liao, Rounds & Klein, 2005), which may impact the acceptability of therapies in other cultures. For example, it has been suggested that the theological foundations of Islam may be at odds with CBT's traditional Western or individualistic values self (Beshai, Clark & Dobson, 2013). A study looking at the views about compatibility of CBT with the values of 34 Pakistani university students found some disagreement in religious values such as fate, individualism, assertiveness and how people relate to others around them (Naeem, Gobbi, Ayub & Kingdon, 2009). Dissonance between cultures which give precedence to community and social interdependence over values of the individual, may conflict with psychotherapies such as CBT, which places emphasis on the self (Beshai, Clark & Dobson, 2013; Hays, 2014). The viewpoint of Western CBT focussing on the individual's autonomy in creating change in cognition and behaviour may also conflict with traditional SA collectivistic values (Beshai, Clark & Dobson, 2013).

This may explain premature therapy dropout by SA clients and the already evidenced underutilisation of mental health services (Bowl, 2007; Netto, 2006; Tabassum, Macaskill & Ahmad, 2000), and may be mirrored in CBT for PG. An awareness of the potential conflict between individualistic and collectivist cultural norms and expectations in

relation to CBT, and an exploration of this issue with SA clients at the beginning of therapy may improve both the therapeutic relationship, the client's experience of therapy and the clinicians understanding of the client's context. Addressing difference and diversity, as suggested by Nezu (2005; 2010) could positively impact the therapy process and aligns with core principles of CP emphasising the importance of exploring client expectations within clinical practice (Hanley, 2010).

Many researchers and practitioners have argued for the modification of these practices for culturally diverse populations (Brown, 2009; Wong, 2005) and consequently, it has been suggested that modified CBT can be effective within multicultural contexts (Miranda,Azocar, Organista, Dwyer & Areane, 2003). In Chinese populations, for example, studies have shown improvements in psychological wellbeing (Shen et al., 2006; Wong & Dean, 2010).

Okuda and colleagues (2009) presented a single case study of a Haitian problem gambler and illustrated how cultural beliefs can contribute to the etiology of gambling and manifest symptoms as per cultural belief. They demonstrated how CBT can be successfully integrated within belief systems of different cultures (Okuda et al.,. 2009). Therapy adaptation for culture has long been on the radar in psychology, but limited research has been conducted in relation to this in SAs for gambling. Other attempts have also been made to adapt CBT for various psychological difficulties in SAs. For example, randomised controlled trials (RCTs) have demonstrated culturally adapted CBT to be more effective than treatment as usual for depression (Naeem et al., 2014; Naeem et al., 2015a) and psychosis (Naeem et al., 2015c; Rathod et al., 2013) and corresponding manuals have been published in which the authors thoroughly outline the process of culturally adapting CBT for different populations (Naeem et al., 2015b). Culturally adapted CBT for psychosis was found to be acceptable in black and SA populations in a preliminary qualitative study in the UK (Rathod, Kingdon, Phiri, & Gobbi, 2010). Low attrition rates and effective outcomes were found when the culturally adapted CBT was executed (Rathod et al, 2013). The cultural adaptation process focussed on a number of features associated with 'culture and related issues,' such as acculturation, religion, values and language. Significant reduction in symptomology as well as low attrition rates were found in 33 males and females of mixed ethnicities in the UK. As a result, Naeem et al. (2015b) recommend culturally adapted CBT for SA Muslims combining collectivistic principles in depression and psychosis in light of their qualitative preliminary studies. However, despite the fact that this study did not analyse minority groups separately, there is growing evidence of the value of CBT in culturally diverse populations (Bennet & Babbage, 2014).

1.9 SA and Gambling

Prevalence surveys in SAs help to illustrate a similar trend seen in other ethnic minortities. In a sample of college school students from South India, 7.1% were described as problem gamblers, which were 25.2% of those who had ever gambled (George et al., 2016; Jaisoorya et al., 2016). They were more likely to be male, experience psychological distress and suicidality, higher substance misuse rates, have ADHD, and have a sexual abuse history, and experience academic failures.

Through focus groups and individual interviews, a study looked at the impact of gambling on the health and wellbeing of Asian families and communities in NZ (Sobrun-Maharaj, Rossen & Wong, 2013). This sample included Indians as an ethnic subgroup. The impact and consequences of gambling on families were found to play a role in the initiation of gambling as a coping mechanism. Other culturally specific factors included acculturation and settlement stress, social environment, social disconnection and family conflict. Although a SA group was included, their specific cultural roles were not explored. All cultures were analysed as a generic ethnic minority group, which does not tell us about the journey of a SA immigrant, to illustrate their high prevalence risks.

Prevalence findings in the UK were further analysed, by conducting follow-up interviews with 589 pooled SAs from the 2007 and 2010 British Gambling Prevalence Surveys. SAs were found to have less positive attitudes to gambling than the white population, possibly reflecting less sympathy for gambling in the SA community. However, the prevalence of PG was the same as white counterparts, illustrating that SAs are equally likely to participate in gambling but relatively more likely to exhibit signs of PG when they do. Furthermore, being Asian was shown to be a predictor of PG after controlling for income, socioeconomic status and level of deprivation in area of residence (Wardle et al., 2011). Asian/Asian British or black/black British were more likely to gamble for enhancement i.e. excitement, achievement or coping. It was not clear whether translators were used to carry out the interviews as this could potentially exclude immigrants with language issues which have been found to add to the likelihood of initiating gambling behaviours (Chan, 2000). Authors of this analysis emphasised the need to understand PG behaviour in SA populations as they have been neglected compared to their SE Asian neighbours. SAs account for at least 4.9 percent of the UK's adult population (Office of National Statistics, 2011). This only includes Indian, Pakistani and Bangladeshi origins. The cultural element evidenced by these prevalence rates has not been sufficiently understood in relation to PG in the UK or elsewhere.

Since we know that gambling is not approved of among the SA population, those who do gamble, do so at the cost of community disapproval. Negative attitudes from the community towards gambling could make gamblers disproportionately likely to take part for relieving tension, a motive associated with high PG risk (Raylu & Oei,

2002). In the 2010 British prevalence survey, SAs were also more likely to categorise reasons for gambling as 'coping' (Forest & Wardle, 2011). Problems are likely to become more severe and risk becoming PG, which may be enhanced by a lack of culturally appropriate services to support problem gamblers (Scull & Woolcock, 2005). It is clear that SAs differ from the SE Asian perception as their culture does not look favourably upon gambling, yet they have an increased rate of gambling. The majority of research on PG has focussed on Chinese and other SE Asian communities. Though current literature is helpful in articulating possible issues experienced by problem gamblers as immigrants, they do not shed light on SA specific cultural difficulties and experiences. As of yet, no literature has explored the cultural role in SA men with PG and the individual ways in which they experience gambling. As recent prevalence surveys in the UK have shown British Asian men to be at higher risk of PG, it is important to review any literature in this population, to understand the role of culture.

1.10 Research Implications

Low participation rates of gambling in SAs imply a lack of knowledge or experience of gambling. Gambling awareness education needs to be considered in order to alleviate the harm that can be inflicted on individuals, families and communities. To do this, it is important we understand specific perceptions of PG and gambling in SA communities. The literature has shown us that there may be underrepresentation of SA problem gamblers in services, as have been witnessed in other addiction and mental health settings (Das & Kemp, 1997; Pearson & Patel, 1998). There have been few studies describing the experiences of help-seeking in PG (and other addictions), which have been linked to cultural and familial perceptions in SE Asian problem gamblers. In SAs, similar attitudes may govern help-seeking behaviours which as of yet, have not been researched in this population. Although there may be similar cultural aspects between ethnicities such as close family structures, the political histories of SA and SE Asians are profoundly different, especially for immigrants who have experienced different cultures, between their native and host countries. This makes it imperative that we understand the journey of PG specific to SAs, and experiences of therapy for those who reach services.

1.11 Conclusions and Relevance to Counselling Psychology

One of the most frequent criticisms of counselling with minority clients is the dissonance between therapists and their clients in communicating and understanding the values, lifestyles, and backgrounds (Sue, 1998). There has been a call for mainstream services to provide culturally competent professionals and not to side-line the clinical responsibility to minority ethnic agencies (Netto, 2006). In the British Psychological Society's (BPS) Code of Ethics and Conduct, the importance of respecting "individual, cultural and role differences, including...ethnicity..., national origin, race, religion" is highlighted (BPS, 2009, pg. 10). Results of the study may guide the development of transcultural therapy which recognises individuals' experience as inextricably linked with cultural context and

therapists are encouraged to develop an understanding of their clients' wider and political context and its impact on the therapeutic relationship and process (Skodra, 1989). Miranda et al. (2005) points out the benefits of learning about the patients' culture as a tool in building trust within the therapeutic relationship, demonstrating openness and interest by recognising the cultural beliefs and role they play in the initiation and maintenance of PG. These all provide advantages in that they can assist effective, meaningful therapy.

This study proposes to specifically explore the experiences of second-generation SA men and views of the CBT they received and how they feel their culture may or may not fit into this. As we don't know what specific SA communities make up the population of at risk PG, SA men will be interviewed as a collective group. This may highlight convergences and divergences between language, ethnicity, religion, and perhaps even cultures. This study seeks to bridge the gap in our understanding of these experiences which may go some way to inform the intersubjective understandings constructed within and about therapy. As the UK is becoming increasingly diverse, CP has a responsibility to adapt to this and become aware of the implications this creates within the context of therapy. Since SAs make up a significant amount of the population in the UK, and continues to grow, it could be argued that surprisingly little research has been done on ethnic minorities and their experience of therapy, when race and ethnicity have been long identified as being salient for both the therapist and clients (Comas-Diaz & Jacobsen, 1991). CP aims to understand the individual in their context and counselling psychologists base their interventions on the subjective experience (Strawbridge & Woolfe, 2010), making this enquiry greatly relevant to the field. Gambling is a relevant issue for clients that will be seen within services from primary to more complex care settings. Understanding their experiences of attending services will be important to allow services to attune to their needs once they arrive. Finally, the findings can be diffused into other mental health disciplines in order to work with this client group in a holistic, relational and pluralistic way as observed within the theory, philosophy and practice of CP (Milton, 2010).

2. Methodology

2.1 Research Design

2.1.1 Qualitative Methodology

The aim of this current piece of research was to explore the subjective experience of male SAs who have undergone CBT for their PG, for which a qualitative approach was considered to be more suitable. As referenced earlier, much quantitative work has been done in the field, but very little research has sought to find out about subjective experiences. In contrast to positivist or quantitative approaches, whose aim is to derive impartial cause and effect, qualitative research maintains that subjective reports are legitimate in their own right, and cannot be understood using measures of frequency (Smith, 2004; Willig, 2008). It therefore affords an exciting opportunity to discover an idiographic understanding of the participant's meaning within their social reality, when experiencing particular situations (Bryman, 1988) i.e. to live with PG and experience CBT. It thus facilitates an understanding of the complexity of bio-psycho-social phenomena and can inform clinical practice (Boyle, 1991).

Qualitative enquiry possesses similarities with the therapeutic encounter which shares the ambition to search for the detailed nuances of subjective experience and meaning, through the collection of individual and personal accounts (Mcleod, 2001; Woolfe, Dryden & Strawbridge, 2003). It appreciates that experiences and perceptions of a given situation have multiple interpretations and thus seeks to understand and represent experiences as they vary from one participant to another, as well as perceptions from the health professional. Through collaboration or an iterative process, a formulation is reached which surmises the history and creates a basis of action. Qualitative work therefore seems congruent with CP philosophy.

2.1.2 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was developed by Jonathan Smith (Smith, 1996) and has three defining features; idiographic, inductive and interrogative (Smith, 2004). The participant's "lived experience" together with the researcher's explicit subjective reflections provide IPA with its idiographic feature (Reid, Flowers & Larkin, 2005, pg. 20), which seeks to understand the individual as a unique and complex entity and recognises that contexts can elicit varying experiences. IPA, unlike quantitative methods, does not limit itself to initially established hypotheses. This inductive nature allows IPA to elucidate themes through emergence, not prediction and therefore contribute to an enhancement of rich understandings in the field. Thirdly, the interrogative process is embedded in the elicitation of themes and patterns that are critically evaluated and described in accordance with extant psychological theory. The dearth of literature in this area makes IPA a fitting choice by virtue of its exploratory nature and emphasis on meaning making of experience (Smith, Flowers & Larkin. 2009). IPA fosters the emergence

of unanticipated findings and difficult to identify or unidentified variables particularly effective for under researched topics (Barker, Pistrang & Elliot, 2002; Smith & Eatough, 2007). This is relevant as the study aims to add to our understanding of male SAs' experience of CBT within existing literature, which could provide counselling psychologists with rich data to enhance and enlighten their therapeutic practice. In the next sections, IPA will be further examined with two key informing philosophies in mind; hermeneutics and phenomenology.

2.1.3 Phenomenology

Phenomenology is a philosophy of understanding experience and maintains that the meaning of reality is shaped from lived experiences (Ponterotto, 2005). Phenomenology is interested in the world as experienced by people within particular contexts, rather than in abstract statements about the general nature of the world (Husserl, 1970; 1982) where experiences are fixed in predefined categories as seen in positivistic methodologies (Smith et al., 2009). Thus, phenomenology maintains an impossibility to neglect subjectivity and views the individual as a contextual entity that is essentially embedded, and interacts within the world it occupies (Larkin, Watts & Clifton, 2006). It is asserted that the experience and meaning of a phenomenon varies depending on individual subjective orientations (desires, wishes, judgements, purposes), also known as 'intentionality' (Husserl, 1970; 1982), meaning that different people perceive and experience what objectively appears to be the 'same' phenomenon in different ways, therefore people's lived experiences should be explored as valid experiences in their own right (Husserl, 1970; 1982). Similarly, IPA seeks to understand the participant's subjective meaning of an experience, which is understood to be representative of the experience itself (Smith et al., 2009).

2.1.4. Hermeneutics

Hermeneutics is concerned with the theory of interpretation, which is considered as necessary to obtain proximity to the individual's true experience. When interpreting phenomena, hermeneutics believe that the interpreter or researcher inevitably brings their prior experiences, assumptions and preconceptions to the encounter which, in turn, influences the meaning-making process (Heidegger, 1962; 1927; Spinelli, 1989). In light of this, hermeneutics conclude that priority should be given to the emerging phenomena, rather than to one's own preconceptions (Heidegger, 1962; 1927; Smith, Flowers & Larkin. 2009; Spinelli, 1989). Rather than attempt the impossible task of eliminating the researcher's role, IPA explicitly acknowledges this exploration of their congruence or divergence from those of the participant as legitimate components of the enquiry. This interpretive dual processing to access experience is known as the double hermeneutic, whereby the researcher is making sense of the participant making sense of their world (Smith, 1996; Smith & Osborn, 2004). In keeping with hermeneutic thinking, IPA recognises the importance of filtering out subjective preconceptions from the researcher using reflective practices, deemed as

fundamental in coming close to the phenomenon at the heart of exploration (Finlay, 2013; Smith et al., 2009). With this in mind, this study acknowledges that the researcher plays an inescapably significant part in this exploration and recognises the need for 'bracketing,' and suspending critical judgements from our own assumptions and experiences in order to understand the participants' perception of that world (Husserl, 1970; 1982). Bracketing was introduced by Husserl (cited in Tufford & Newman, 2012) in order to mitigate the above affects of the researcher's presuppositions in order to increase rigour. It can also enable the researcher to go deeper into their reflections as it spans the entire process of therapy. The importance of bracketing for this project was not to abandon, but to set aside pre-existing knowledge, assumptions, beliefs and values and to engage in ongoing self-reflection (Starks & Trinidad, 2007). The bracketing methods used were writing notes on engagement with the data during data collection and analysis, including cognitive processes and observations (Cutcliffe, 2003). The interview schedule was bracketed amongst peers prior to interview in order to remove any potential biased questioning based on the researcher's experience. Discussion with the supervisor and viewing the transcripts together added valuable insight, since the supervisor was not present during the interview and thus often came up with a different viewpoint and focus of conversation. Finally, a reflexive journal was kept throughout the research process in order to further "sustain a reflexive stance" (Tufford & Newman, 2012, p. 8). These notes have been written as part of the two reflexive statements within this thesis (see sections 1.1.2 and 4.5 on reflexivity and the results section for further observations). Alongside these measures, supervision was utilised to keep a check on these procedures, and to reflect on the material gathered in order to make decisions, particularly during analysis.

Hermeneutics and phenomenology share a common primary aim; to examine phenomena as they present themselves to people (Heidegger, 1962; 1927). In parallel, IPA is concerned with participants' accounts as reflecting their attempt to make sense of their experience (Smith et al., 2009). Both phenomenology and hermeneutics believe that people's interpretations of phenomenon are undoubtedly shaped, limited and enabled by language and culture (Heidegger, 1962; 1927). This is known as symbolic interactionism (Mead, 1934), which posits that the meaning an individual ascribes to events are of central concern but are only accessible through an interpretative process. Additionally, people's sense-making is viewed as occurring in, and as a result of people's varied relationships and social interactions, which may be further refined through self-reflection.

Furthermore, IPA appears to be highly relevant to CP in which the search for understanding and meaning is paramount and in which engagement with subjective experience is at central focus. They also jointly appreciate the continuous modification and revision in order to encapsulate new perceptions and ideas, similar to ongoing formulations within client work.

2.1.5 Consideration of other Qualitative Methods

Other qualitative approaches were considered at development stage. These potential alternatives and the rationale for their fit for the study are considered below. Grounded Theory (GT) facilitates the exploration of social processes of why and how a certain phenomenon might be taking place (Willig, 2001) and aims to develop a theoretical model. In contrast, IPA aims to keep a close focus on the meaning by attempting to gain an insider's view of the participants' experience of their world (Creswell, Hanson, Plano, & Morales, 2007; Glaser & Strauss, 1967). GT is a worthwhile topic, that has been little investigated, which would overcome a criticism that IPA does not enable us to understand why participants experience events (Willig, 2001). However, the intention of this study was to understand the experience of SA problem gamblers who undergo CBT, as opposed to building a 'theoretically saturated' approach (Strauss & Corbin, 1990) of social processes that partly explain the phenomenon, as IPA does not seek to produce claims for the broader population within a larger sample in the form of social processes (Willig, 2008). Willig (2001) further suggests that IPA represents a more psychological focus compared to the sociological focus of GT and therefore is deemed suitable for accessing participants 'lifeworlds' (Smith & Osborn, 2008).

IPA's approach is also distinct from Discourse Analysis (DA) which fundamentally examines the *role* language plays in describing individual experiences (Potter & Wetherell, 1987) and how language constructs reality. Language is viewed as a descriptive verbal 'behaviour' in its own right, and dialogue is analysed in accordance with functions and activities performed in a certain situation. Although language shares an important role in IPA, it explores how people ascribe *meaning* to their experiences in their interactions with the environment (Smith, Jarman & Osborn, 1999). DA's stance is critical of the cognitive paradigm (Starks & Brown Trinidad, 2007), and the differences in the way social cognition and experience of the self and body is perceived is where its approach diverges from IPA. IPA accesses an individual's cognitive internal world by using language to gain insight into individuals' thoughts, beliefs and experiences of the phenomenon (Chapman & Smith, 2002). It assumes a 'chain of connection' between verbal responses and how individuals think and feel about themselves, others and the world i.e. between thought and speech (Crossley, 2000; Smith, Flowers & Osborn, 1997). The greater relevance IPA applies to cognitions and what the participant understands about a given phenomenon (Smith, Jarman & Osborn, 1999) allows the idea that experience is not completely constrained and defined by language, deemed pertinent to the current study. In DA, the chain of connection between language and the experiencing 'self' is questioned, preventing the enrichment of subjective thoughts and feelings about the phenomena (Abraham & Hampson, 1996). It is argued that IPA provides an image of lived life with its entire vicissitudes, including language and cognition as a complex, nuanced process of sense and meaning making and can provide more understanding than solely historically situated linguistic interactions (Eatough & Smith, 2006). Whilst due consideration has been given to DA, IPA was selected to answer the research question as its interpretative methodology makes it possible to access an individual's cognitive inner world (Denzin & Lincoln, 1994).

IPA has also been deemed as being more informative in its further interpretative analyses, which goes beyond standard thematic analyses (Brocki & Wearden, 2006) and in terms of clinical implications (Warwick, Joseph, Cordle & Ashworth, 2004). This is possibly through a greater engagement through interpretation with the data to provide rich descriptions. IPA's analytic process maintains a level of focus on distinct idiographic features between people, but also attempts to balance this against commonalities across a group of participants in order to produce a detailed account of patterns of meaning for participants reflecting on a shared experience (Reid, Flowers & Larkin, 2005; Smith et al., 2009). Thus, IPA has been chosen as the most appropriate tool for analysis in capturing a full and in-depth understanding of this under-researched group. Similarly, CP valorises subjectivity and context in both research and practice (Orlans & van Scoyoc, 2008).

IPA sits well within a social constructionist positioning due of its emphasis on context and experience, and consideration of related social, cultural and historical factors (Eatough & Smith, 2008). This view sits comfortably with the researcher's philosophy that people actively perceive and create ever-changing meaningful subjective worlds influenced by and interpreted in their socio-cultural contexts. Although it comes with a procedural guide, IPA recognises research and analysis as a dynamic process (Smith, 1996) to be applied flexibly, whereby researchers take an immersive and active role in the process of interpreting participants' meaning (Smith, Jarman & Osborn, 1999). Therefore, results provide joint reflections and meaning making from participant and researcher (Osborn & Smith, 1998). Although interpretations of the content are acknowledged as helping to represent participant meaning, caution is taken. Subjectivity must be reflected upon and made explicit as the researchers' own values, beliefs, background and experiences (Sword, 1999) can complicate full access into an individual's personal world, since "there is no view from nowhere" (as cited in. Larkin, Eatough & Osborn, 2011, p. 325). To achieve this, engagement in reflexivity is fundamental to ensure a rigorous and robust analysis that comes close to the heart of the phenomenon (Finlay, 2013; Willig, 2013).

2.1.6 Epistemological Considerations

Counselling psychologists situate themselves within a humanistic framework (Strawbridge & Woolfe, 2010) and core values state the importance of an individual's rich subjective and intersubjective experience as valid, and their position as socially and relationally embedded beings (Cooper, 2009; Woolfe, Strawbridge, Douglas, & Dryden., 2010). It emphasises the importance of understanding their "insider's perspective"(Conrad, 1987, p. 53), parallel to the pluralistic paradigm, which appreciates the diversity of people with different cultures, experiences, beliefs and attitudes (Cooper & McLeod, 2010). IPA hopes to extract a subjective essence from each participant through themes emerging from the data (Creswell et al., 2007). Obtaining a deeper understanding of what may be experienced by this population can provide counselling psychologists with rich, accessible information when it becomes appropriate

in the therapeutic encounter. In line with this, there has been an epistemological drift towards a postmodern pluralistic stance from a traditional positivist model, which emphasises objectivity and truth claims about knowledge (Woolfe et al., 2010). Positivists claim a 'closed systems ontology' (Bhaskar, 1997) whereby reality is seen to fit a model of how the world sees reality, which misconstrues reality.

Other post-positivist epistemologies, such as critical realism, focus on a source of knowledge to justify knowledge claims, which seeks to base positive development and application of scientific knowledge on a realist vision of science. Therefore, understandings of socially defined and negotiated realities are toned down in favour of an exploration of objective deep structures and mechanisms. Social constructionism purports that knowledge is constructed socially, historically, culturally and linguistically. Social constructionists claim to know reality as socially constructed expressions of power (Burr, 2003). It aligns itself with a relativistic epistemology which states that all knowledge is relative to one's location within a set of social norms (Potter, 2003). Scepticism is fostered to see neither knowledge as connected to power, and to de-legitimise these as neither certain nor fallible true statements about reality (Cruikshank, 2012). The aim of empirical research, therefore, is to undermine all objective knowledge claims of truth, and to foster scepticism that recognises and destabilises constructions of reality that serve to reproduce these existing power relations. IPA has been widely regarded as aligning with this (Smith & Osborn, 2004). It is pertinent that the chosen methodology be congruent with the researcher's epistemological position (Willig, 2008), as well as the values underpinning CP (Ponterotto, 2005). This study is not concerned with accurately identifying and measuring a 'true' account of an independently existing singular reality, but seeks to focus on providing rich, comprehensive descriptions and interpretations of SA men's subjective experiences and perceptions of the phenomena of CBT for PG, which communicates a sense of texture and quality at its essence. From within this framework, this study accepts that alternative interpretations are inevitable and equally valid, but do not invalidate the interpretations resulting from this study. However, it is acknowledged that interpretations need to be evaluated by initially assessing the extent to which they are borne from the meeting of researcher and text (Smith et al., 2009).

2.2 Participants

The inclusion criterion for participating in this study was being a second generation male adult of SA background who had experienced CBT for problem gambling in the past year. Participants were seven second-generation SA[3] men from an Indian (five), Sri Lankan (one) and Pakistani (one) background aged between 23 and 44 years of age. Four of these had undergone or were undertaking group CBT therapy and three had undergone or were undertaking individual CBT therapy. None of the participants were of mixed ethnicity. All seven participants were recruited from an NHS Trust providing a service for problem gamblers (see participant details in Table 1 below).

Pseudonym	**Age**	**Ethnicity**	**Religion**	**Mode of CBT**	**Attended therapy before**	**Presently Gambling**	**No. of sessions during most recent CBT**	**When undergone CBT**
"Raj"	31	Indian	Hindu	Individual	No	Yes	4 (dropped out)	2015
"Ajay"	29	Indian	Hindu	Group	Yes	No	7	Current 2012
"Deva"	27	Sri Lankan	Hindu	Group	Yes	No	5	2016 2015
"Sandeep"	44	Indian	Sikh	Group	Yes	No	8	2016 2015
"Faraj"	29	Pakistani	Agnostic	Group	Yes	Yes	8	2016
"Aman"	39	Indian	Hindu	Individual	Yes	Yes	9	2017
"Samir"	23	Indian	Hindu	Individual	Yes	No	5	Current

***Table 1*: Participant demographics and characteristics**

[3] SA ethnicity was defined as being from one of the following countries: India, Pakistan, Bangladesh or Sri Lanka. SAs have a vastly similar background, and in the UK, they are seen as roughly part of the same group in terms of their collectivist culture within services and research, irrelevant of religion, and have been identified as a group likely to be at high risk of PG. This criterion was also used to reduce the risk of recruitment difficulties, as this population has been known as difficult to recruit to mental health research (Mason et al., 2003).

IPA is concerned with the convergence and divergence in a homogenous sample. Although the literature points to males being at increased risk of PG; their experiences in the UK context have not yet been qualitatively examined. This research seeks to understand their experiences better. Therefore, only males were invited to take part in order to create homogeneity. Similarly, due to possible differences in language and cultural perceptions, only second generation SA males with high proficiency in English were approached. As IPA plays close attention to experience though meaning-making and language, difference in languages and the use of translators may have complicated analysis and led to the doubling of hermeneutics. Fewer participants examined at a greater depth have been viewed as preferable to a broader and descriptive analysis of many individuals (Reid, Flowers & Larkin, 2005). Adequate contextualisation in a purposive and homogenous sample, with a small sample size of 6-8 have been recommended as providing a sufficient perspective of a group without acquiring overwhelming amounts of data for the purpose of a professional doctorate (Smith, Jarman & Osborn, 1999; Smith & Osborn, 2004; Turnpin et al., 1997).

It might be suggested that the sample is not homogeneous enough, owing to the inclusion of both group and individual therapy. However, arguably the sample was reasonably homogenous with relevance to many other factors (generation, ethnicity, gender, experience of CBT, therapy within the last year, therapy from the same service). Moreover, the inclusion of participants in either group or individual therapy made it possible to recruit, since there was a limited pool of potential participants who were SA and male, a population already deemed as hard to reach (Bowl, 2007; Netto, 2006; Tabassum et al., 2000). Additionally this NHS clinic is one of its kind in the UK. Greater homogeneity could have been achieved through the exclusion of either group or individual therapy, but it is highly likely that an acceptable sample size would not have been met. In order to create the greatest comprehensive analysis, a small heterogeneous trade off has been made. This method also encouraged the emergence of any potential convergence or divergence within the data. The aim of the project is to understand the experience of CBT in SA problem gamblers, but it was not focusing on the similarities or differences between the two types of therapy format, which we do not know how or if they are experienced differently, since this has not been the focus of the phenomenon. The phenomenon under investigation was the experience of receiving CBT within the NHS when you are a male, second generation SA male. Both formats are relative to experiences as it is likely that more than one is experienced in their therapeutic journey of PG in the real world i.e. 4 out of 7 of the participants had experienced some form of both individual and group therapy. Consequently, the fact that the majority of the participants had experience of both formats of CBT could be arguably providing the study with more 'impact and importance' as required by Yardley's (2000) 4 principles of qualitative research.

2.3 Recruitment Process

Potential participants were recruited by accessing a database of those who had agreed to be contacted about research at the point of assessment. A list of eligible people beginning with those who had completed therapy in the last year to those currently in therapy was obtained. Those who had been in CBT therapy over the last year were contacted in order to gather a sample less likely to be confounded by difficulties in memory recall. The first seven to agree to take part were interviewed. Eligible individuals were given a phone call to provide a brief description of the study. All calls were made between 9am and 5pm in order to respect people's personal time. Messages were not left in order to protect confidentiality in case of shared phones. Interested individuals were sent an information sheet via email as was each of their preference (see Appendix A.4). A follow up phone call was made by the researcher to gauge interest approximately one week later. Interested people were invited to attend the NHS service or public location and consequently, screened. Informed consent was taken by the researcher (see Appendix A.5). The interview questions were trialled amongst course peers in order to monitor its fluidity and acceptability for participants (Grbich, 1999).

Participants were given the option to be contacted to check the accuracy and resonance of the themes developed from an initial analysis, with their experience, in order to reduce researcher bias and keep within the phenomenological frame of the participants. However, two out of seven participants declined this offer at consent stage. Out of the remaining participants who were approached, no-one was interested in looking at their scripts.

2.4 Ethical Issues

In order to screen people who were at high risk of mental health distress, the Physical Health Questionnaire 9 (PHQ-9) and Generalised Anxiety Disorder 7 (GAD-7) (Appendix A.3) were used to measure the risk of depression and anxiety respectively. No participants were deemed ineligible due to risk. Up to ten minutes were spent with participants after the interview to go through the debrief form outlining sources of support (see Appendix A.8) in order to discuss any issues arising from the interview process. A distress protocol was on hand (see Appendix A.9) should any distress or risk have arisen as ethnic status has been regarded as a sensitive topic in BPS Code of Human Research Ethics (2010). However, this was not required for any interview. All interviews were conducted in a library or the gambling service from which they were recruited to avoid risk to the researcher.

Throughout the research process, the researcher was studying a Professional Doctorate in Counselling Psychology at a British University, from whom ethical approval was obtained (see Appendix A.2) on addition to the NHS Ethics Committee (see Appendix A.1). Full written informed consent was obtained and the opportunity to withdraw without consequence at any point during the interview and up to 2 months later was made explicit. A consent withdrawal

deadline was set, so that information already gathered was not lost without enough time to find a replacement participant. The confidentiality contract was also made explicit to the participant prior to consenting (See Appendix A.5, statement 3). This involved informing the participant that any concern of risk of harm to themselves or others would need to be escalated to the appropriate authorities.

In accordance with the Data Protection Act (1998), transcripts and audio recordings were allocated an identification number and transferred to an encrypted data stick and kept separate from signed consent forms, which was stored in a locked cabinet within the service they were recruited from. Anonymised audio recordings and transcripts will be kept electronically until no longer needed for publication purposes. Finally, the researcher obtained an honorary contract with the NHS Trust, whilst adhering to its policies.

The role of the researcher being independent from the service and maintaining information as confidential was made explicit throughout the process. This was to be especially mindful of people currently in therapy, as this may have become confusing for the participant. One participant was interviewed at the service. Since the researcher had previously worked at this setting, they were mindful of a dual role as a previous therapist in their organisation, such as awareness of their therapy manuals and knowing therapists personally. No one previously on the researcher's caseload was contacted in order to avoid conflicts of interest. There may have been subtle issues that arose as a result of working in a previous placement setting. For example, the researcher felt an urge to provide therapeutic support based on their clinical experience in this service, as a response to the participants' material, and often felt compelled to correct or enlighten the participant regarding their gambling therapy. This would have had a confounding effect against the aim of uncovering subjective knowledge and understandings of the participant, which is at the heart of IPA. It was therefore important to be careful not to blur role boundaries considering the researcher's other trainee counselling psychologist capacity i.e. by empathising or offering therapeutic advice. Using research supervision and a research diary wherever possible, the researcher was made aware of any feelings they experienced which made their current role with the previous one difficult.

2.5 Data Collection

Qualitative interviews fit well with IPA as they facilitate participants to reflect on their expertise in a subject that they are seen as experts in: PG and CBT in the life-world of SA men (Ashworth, 2003). Semi-structured interviews (see Appendix A.7) are commonly used for IPA research processes (Smith, Jarman & Osborn, 1999), as they are appropriate in understanding the experiences surrounding a certain phenomenon, such as gambling. It allows the researcher to engage in the disclosure to enable fluidity and natural experiences to emerge in light of participant responses. Anchored open questions enabled the participant to explore answers freely and further questions written

in bullet points were asked to prompt further disclosure to create a set of individual descriptions comparable to all other participants. However, as mentioned previously, it was necessary to 'bracket' any ongoing reflections in a reflexive diary which arose during the interview process by being aware of them and attempting to put them to one side, whilst concentrating on accessing pure data from the expert participant (Silverman, 2013). The structured parts of the questionnaire enabled the research participants to be contrasted with each other in order to explore the experiential convergence and divergence mentioned earlier.

Interviews lasted for approximately one hour, and were audio recorded using a digital recorder. A ten-minute briefing was held before the interview in order to answer any questions and obtain informed consent. A further ten-minute debriefing session was held after the interview (see Appendix A.8). A demographics form was completed with the participant after the interview (see Appendix A.6).

2.6 Data Analysis

The interviews, transcription and analysis of the data were done by the researcher alone. The audio recorded interviews were transcribed verbatim (see Appendix A.10 for examples) and given line numbers. These were systematically analysed in conjunction with the audio version using IPA principles outlined in a procedure by Smith & Osborn (2008). To become fully immersed in the narratives, each transcript was read several times (Smith, Jarman & Osborn, 1999) and systematically analysed in turn. Descriptive notes were written on the left hand margin (see Appendix 10) relating to preliminary ideas pertaining to the essence of SA men's' experiences of CBT for PG. Thorough studying of the transcript further developed preliminary ideas into refined emerging subject themes, together with links to psychological concepts. These emerging reflections were noted on the right hand side (see Appendix 10). Notes were continuously modified in order to accommodate the fluid nature of interpretations. Similar themes emerged on the right hand side after going through the full transcripts. Lists of substantive themes (from the right hand notes) were compiled on a separate piece of paper, and after further detailed reading of the transcript, similar substantive themes were clustered together to create more tangible subthemes. After following this procedure for each participant, similar interpretations from different participant transcripts were grouped together. These themes were then analysed against the original texts in order to validate interpretations, and eventually super-ordinate themes were created to describe similar concept subthemes as a whole. The author's version of a spider diagram (see Appendix 10) was created to group together similar themes for each participant, which were eventually merged into superordinate theme. The most salient themes were kept and others discarded. Unrelated themes initially generated were dropped during the analytic process when they appeared isolated from emergent theme clusters. Finally, these were organised into a structured master table of themes highlighting the main features which

encompassed quotations provided by participants (see Table 2 in the following section). As an adjunct, phrases to support the themes were compiled.

Arriving at the final three superordinate themes was a difficult process. There was a lot of material but focus had to be kept on the research question. At first there was some separation between group experiences and individual experiences and through supervision it became clear that focus should be brought back to CBT as a type of therapy rather than the format of the CBT, as IPA is not concerned with comparison and this was not the point of the study. Much of the material about culture and, at first, the quotes were large and it was challenging to decide what to include and what to focus on. There was an attempt to give a voice to all the participants, and a strong sense of responsibility to do them justice. Eventually, the word-limit and scope of the research question became the guides for inclusion and elimination of subthemes and superordinate themes, which led to the often difficult task of losing quotes. This includes the struggle aforementioned in the analysis observations which ended in the integration of the themes of "cultural pressures" and "identity" into the subtheme "struggle for identity," and the emergence of "experience of learning through the CBT framework" as a superordinate theme. Transcripts were revisited many times, and discussed with peers and in supervision in order to facilitate validity checking by comparing against original transcripts as described earlier.

3. Results

Analysis of seven semi-structured interview transcripts resulted in the categorisation of three master superordinate themes and nine subordinate themes. These have been summarised in Table 2 below.

Master Theme	Subthemes	Quotes
1:Experience of Psychotherapy	i: Preconceptions of therapy	*"...you just think people sitting in a circle and talking..". [Raj; lines: 59-60]*
	ii: "What goes in the room stays in the room"	*"...I don't really need to worry... that she is gonna go and discuss it..." [Raj; lines: 46-47]*
	iii: "Not being alone in it"	*"...it's like learning you have a problem and not being alone in it..." [Faraj; lines: 275-276]*
	iv: The format of therapy	*"...individualise therapy towards the patient rather than general therapy with the group." [Ajay; lines: 518-519]*
2: The Role of Culture	i: "What will they think?"	*"...[If] I put my hand up and said, 'gambling addiction', I'd be lesser to the person I'm standing next to." [Samir; lines: 518-519]*
	ii: Struggle for Identity	*"I'm British, this is what it means to be British is I can look at anyone and I'm the same as you kinda thing. I've had to fight that stigma day in day out." [Deva; lines: 794-796]*
	iii: The Burden of Family Knowing	*"[Mum's] very devastated in terms of the impact it's had, on the family." [Sandeep; line: 469]*
3: Experience of Learning through the CBT Framework	i: Experience of Learning CBT Strategies	*"...its just how your mind works...* and how do I control these feelings" [Deva; lines: 23-25]
	ii: Experience of the Role of Culture in therapy	*"If you're trying to treat the patients, it's better to understand what they're going through themselves first in their life." [Ajay; lines: 419-420]*
	iii: The Aftermath of Therapy	*"...when you get the homework sheets and stuff, actually do it..." [Deva; lines: 486]*

Table 2: **Master superordinate themes and subordinate themes.**

This section illustrates each super-ordinate theme and their corresponding subthemes. Each theme will be described in detail, and grounded using verbatim[4] examples from participants in order to reflect and capture their experience. Themes are not necessarily considered as independent from one another and may therefore share commonalities and some degree of crossover. Any perceived interrelation across themes will be mentioned. Themes were also formed based on the research question and therefore may not represent all aspects of participants' experiences.

Observations

During the analysis process, many observations were explored in order to make sense of the material and to reflect on any impositions that may have arisen during the analysis as part of the bracketing process. Before beginning, I had a strong preconception about individual and group dynamics and questioned the ability to address culture safely within a group environment. The topic of format became a prominent subject during the interview, for which my own opinion about the preference of individual therapy being more appropriate in meeting the needs of this population may have been evoked. I found myself trying not to steer the subject on or off it, and tried to allow it to form organically but I am aware it is not possible to 100% reject my perspective. I may have aided this by asking further questions often picking up on their specific questions about the mode due to the curiosity of exploring something I believed in.

Cultural aspects were similar, but with different angles i.e. format, the ability to talk about it depending on the influence of cultural pressure on identity formation. Some may argue that these two should fall into the culture category but the context meant I felt it was sufficient to have its own independent theme as well as being mentioned in other superordinate themes, such as 1.iv and 3.ii. Culture was a theme that became big which meant that was broken down into many unanticipated subthemes. This was both exciting and difficult as I struggled to fit this rich information in to themes.

Throughout the analysis, there was a common narrative and feeling of participants 'hiding' their difficulties from people close to them, including their family, in order to protect their reputation. Some admitted this openly during interviews and informed me that attending therapy helped them to become aware of this. Despite opening up about this, most still seemed to find it difficult to expand on certain feelings with me. I made an assumption that this was based on a preconception that SA men will not talk about their feelings openly due to a fear of being judged as

[4] Some changes have been made to the verbatim extracts to make improvements to readability. Hesitations, word repetitions and utterances such as "umm" have been removed unless deemed relevant. Square brackets have been used to explain what a participant is talking about if it is not clear as well as to remove or change identifiable data. (...) denotes missing material that has not been deemed necessary to include. Dotted lines before or after segments indicate whether text has been taken out of the middle of sentences. Pseudonyms have been provided for each participant to protect their anonymity.

'inferior.' Others declared that their culture did not make any difference to how they have coped with their gambling. Some also mentioned feeling British overall and emphasized that everyone has the same culture. However I noticed a contradiction between what had been said and what I was reading. Some even confirmed that they were unable to open up in therapy, with other group members and this struggle was evident to me as an interviewer. It was difficult to put this into its own subtheme as it appeared in various other subthemes, particularly throughout the culture subthemes. Different slants on the topic of hiding things from others meant that it seemed to fit better within different subthemes as a finding.

Section 2.ii was going to be split into subthemes incorporating "pressures" and "identity", but then came a realisation that these two are interlinked and that cultural pressures had an impact on participants' identity. There was also a sense of masculinity that I felt throughout the interviews. However, as this rarely came up explicitly, I felt that this did not justify a separate category, and fell into other themes organically.

It was difficult to distinguish between certain themes and superordinate themes and, as a result, the final superordinate theme "experience of learning through the CBT framework" emerged late in the analysis. It had become apparent upon further analysis that the last theme was to do with how participants viewed the process of therapy as having affected them and how they applied the information going forward with regards to the framework of CBT and their reflections on the experience of learning. Within this, "the role of culture within therapy" seemed to fit best. This is in contrast to "experiences of psychotherapy," which focuses on the experiences prior to and with regards to the experience of being within a psychotherapeutic setting.

3.1 Experience of Psychotherapy

Participants recounted experiences of the many different components that encompassed psychotherapy. This is presented, beginning with preconceptions before therapy, followed by experiences during therapy such as it being behind closed doors and having someone to talk to, and followed by the format of therapy.

3.1.1 Preconceptions of Therapy

All participants had a view of therapy before attending the CBT sessions, mostly concerning group therapy. These views appeared to be influenced by previous experiences of therapy for their gambling or other mental health issues as well as images about what therapy would entail. These observations will be presented in this section.

The following excerpts describe preconceptions of therapy, which ultimately seemed to influence what mode some participants undertook for gambling therapy.

> *... maybe from TV or things like that you just think people sitting in a circle and talking (...) I think having to listen to people going round and saying all their [troubles] I think that would just burden me (...) sort of wears me out do you know oh my god, oh my god I mean I am worried about my life and worried about people's (...) [It's] depressing to hear.* [Raj; lines: 58-64]

Raj talked about potential overwhelming experiences, where it would be "unbearable" to hear others' stories in addition to his own unbearable problem. He seems to expect a certain responsibility of carrying others' problems and being unable to separate them from his own, and feels as though he would take them on as a "burden" and be unable to cope. It is potentially unsurprising that he later went on to choose individual therapy due to a perception that he might become depressed there. These preconceptions seem to have come from the TV and media about what group therapy would look like, without Raj having experienced it himself. Below, Samir has conjured an image of individual therapy.

> *...social perception of a therapist is, you lying down on a sofa, head back, talking about all your problems and.. paying a shed load of money and, you're suddenly meant to walk out feeling happy and rosy.* [Samir; lines: 39-393]

Samir's image of individual therapy entailed someone sitting, speaking, listening, and taking money. This perhaps suggests an underestimation of the power of those interventions and saw therapy as passive and something that is 'done'. His perception of talking and paying vast amounts of money is seen as one is meant to leave therapy feeling fine, as if by magic, giving the sense that he is dismissive of the value of therapy and perhaps disregards it. However,

Samir experienced individual therapy before and decided to have individual therapy again, implying that the previous expectation is something his previous experience of therapy may have dissipated. Raj may have also chosen individual therapy due to a perception of groups formed from media accounts.

The following excerpt describes the experience of other members during a previous experience of group therapy:

> *... but eventually (...) you kind of build this team (...) when everyone expresses their thoughts about their gambling experiences, because I am someone like them I'm sympathetic to their situation so I can connect to them in those terms so, from week two or week three onwards I'm kind of comfortable within the group so.. I'm quite happy to express myself, but there are obviously a few things I hold back.* [Deva; lines: 109-115]

In the group setting, Deva states he did not feel related to other group members when he first met them. He shared that he felt more comfortable the more sessions he went to. One of the things that concerned him was being categorised with members who don't look "normal". Later, Deva began to feel sympathy towards group members and formed a connection, after which the prejudices dissipated, and now regards himself as part of the "team". This resulted in Deva seeking more group therapy. Although he felt more "comfortable" and able to "express" himself, Deva also mentions that he holds back on some things (discussed in 3.1.4).

> *If it was a group session then I would have been very uncomfortable because (...) I have been to one session before (...) this is ages ago (...) you think "oh my God, I'm not as bad as him (...)" yeah. And that was my... perception from twelve years ago, you know. I'm quite well educated, I've got quite a good job, I can't relate to these guys. And maybe there's the other eleven guys in the room probably thought exactly the same about me...* [Aman; lines: 44-47, 406-409]

Aman appears to perceive himself as different to other group members and recalled prejudices towards them in a one off group session years ago. He appears to show a sense of superiority as though he is not in the same "bad" place as others. It could have been a realisation of the extent of his difficulties leading him to feel defensive. It took him 12 years to return which has implications for problem gambling development, due to this deterrence from seeking therapy, which meant that he was keen to experience individual therapy on this occasion. In Deva's experience, he was able to connect with participants the more sessions he went to. In Aman's case, it could be argued that one session may not have allowed him that time to become more comfortable before deciding it was not for him. This may have determined his decision to currently undertake individual therapy. Perhaps the non-comfortability is about shame and having to save face in front of others. Not only might he feel a responsibility to himself to change but also to the group, who may pass judgment. This may feel too pressured, resulting in him not re-attending group therapy. These extracts highlight the fact that being in group therapy can impact people differently.

There is a sense that these preconceptions are ones that men experience more broadly i.e. media portrayal (Machlin, King, Spittal & Pirkis, 2014), comparing themselves to others in the group and fearing the effects of disclosure (Roback, 2000). Ideas unique to SAs may be driving these preconceptions i.e. not talking outside the home as it's not safe or not family (Khan, Shabir & Ahmed, 1995; Wanigaratne et al., 2003); therapy is unfamiliar territory in the community (Sheik & Furnham, 2000).

3.1.2 "What goes in the room stays in the room"

The following subordinate theme explores a big part of most participants' experience; being able to speak to someone in a confidential setting.

> *...someone I don't know I don't really need to worry (...) that she is gonna go and discuss it with, she [might] discuss it with her other colleagues or whatever, but she's not really, I'm not really gonna see her.* [Raj; lines: 45-48]

Raj appeared to find it useful to be in the company of a stranger in a private setting, without the fear of reprisal. It seemed important to him that nobody knew about his gambling problem. In a group setting, Raj may have worried that people might talk to others about his problem and therefore would not remain confidential. Speaking to a complete stranger on his own in a confidential setting seems to have dissipated this fear. It may have also helped that the therapist was external from his community, which could have alleviated possible feelings of shame. There may be a fear of judgement where he worries that if people would know he is in therapy, he may fear losing face in the community.

> *... she didn't know my past, she didn't know the reasons why I gamble (...) She's opened my mind up to different scenarios. Coping (...) it's the fact that, I guess it's what goes in the room stays in the room.* [Samir; lines: 330-333]

Again, Samir emphasises the secrecy of the room and the non-judgmental nature of the therapeutic relationship which considers him at face value. Feeling comfortable in this way may have allowed him to open up and consider various scenarios.

3.1.3 "Not being alone in it"

The following subordinate theme describes participants' experience of being in therapy making them feel as though they are not alone.

> *… it's like learning you have a problem and not being alone in it and knowing that there are people to actually help you, and in some effect strangers, 'cos family can always help you, but they're (…) someone who's not personally indebted to you, so a practitioner who's an expert on that (...) it's not something that's kinda like "oh, you're just lost to the world now. Go deal with it."* [Faraj; lines: 275-281]

Faraj talks about feeling alone without help in the form of therapy, and mentions that having a stranger who is an "expert" is reassuring, and refreshing as a difference to someone who knows him who he is "indebted" to. An expert may provide a sense that they are more understanding and non-judgemental than other people in their life. Faraj is emphasising the relief in knowing there is help out there that makes him feel understood, as many participants seemed to be unaware of previously (See theme 3.1.1).

Participants such as Samir cited the fact that their therapist listened as opposed to giving advice of main importance in their therapy.

> *I see it as opening up (…) as opposed to having someone who is trying to sit on the other side and teach you about like, that comes as part of it. Having someone to talk to about the way your brain works and.. ways you can cope, but for me, it's about having someone on the other side of the room that I can just talk to. 'Cos there are times when you feel lonely, as a gambler, regardless of the number of people that you have in and around you.* [Samir; lines: 52-58]

This illustrates that Samir may feel his life is lacking a space to talk about his feelings; a void which therapy seeks to fill. Samir explains that having many people around him does not necessarily mean he has this quality of relationship in his life. He may not feel able to open up to them in the same way he can in the therapy room, which seems to have compounded a feeling of loneliness.

> *When I told [my therapist] that [my parents] cleared me a few times she's now thinking "oh, well you've gone in there and you keep doing it because you know they're gonna clear it" (…) at the beginning I was happy to talk and be honest and things and then, it just started "oh I've got to go and talk to her again." [Raj; lines: 202-221]*

Raj seems to regard his therapist as judgemental and having made an assumption that his parents were going to clear his debt and this is why he continues to gamble. The non-judgemental element that other participants had been grateful for seemed to be missing from Raj's experience, which may have caused him to be less open later on in therapy. This may have led to him feeling alone and criticised, leading to resentment and possibly a reason for him to stop attending therapy prematurely.

3.1.4 The Format of Therapy

All participants described their experiences of being in their respective modes of individual or group therapy, a subject which became a strong factor in their experience. The following extract describes Ajay's thoughts about his ideal therapy:

> *...it could be tailored to my needs to be, in terms of what I go through as an individual on top of my condition and linking that with the gambling as well as the medication together (...) individualise therapy towards the patient rather than general therapy with the group (…) my experience is different to everyone else (...) [In group therapy] there's certain things I wouldn't disclose apart from saying how often gambling, the reasons for doing gambling (...) but if I had individual therapy, CBT therapy, I would actually be able to elaborate a bit more what's going on in my experiences...* [Ajay; lines:475-476, 518-519, 266-280]

Here, Ajay suggests that his therapy could have been individualised towards his needs, especially as he suffers with a comorbid psychiatric condition for which he takes medication. This way it would take into account his needs as a whole as opposed to what he calls "general" therapy in the group. It appears as though Ajay never felt that his needs were acknowledged as an individual in the group and describes his experiences as different to others'. He goes on to report that he would be able to "elaborate" and disclose personal experiences in individual therapy, and states that he was unable to do this in group therapy, apart from behaviours specific to gambling.

> *...we did the session on triggers and I think everyone's pretty clueless about what their triggers were. But you need to talk about the stuff that's going on in your life, right. To suddenly kind of stumble upon it (…) in your mind a lightbulb just goes off and goes "oh that was a trigger" (...) it's very difficult to connect with [the facilitator in a group] on an individual basis (...)I really want to talk to her about (...) my life and (...) what can I do potentially to address those issues (…) because off the back of this I now start talking to people and I'm open to people close to me.* [Deva; lines: 360-384]

Deva further expands on Ajay's observations and offers an explanation of the importance of individual therapy. He suggests that it may help an individual to explore and discover their triggers, which can be found if people are able to "stumble across them." In group therapy he recalls witnessing others being "clueless" about their triggers, which Deva believes could be found during individual therapy and perhaps therefore enhance the benefits of therapy. Deva goes on to reveal that the group (as well as previous individual therapy) has allowed him to be comfortable with being open and that he feels compelled to talk about the cultural impact on his life and gambling. He has even sought this but feels that he did not build a relationship with the facilitator. This has implications about a need to address this issue for some participants, which may feel impossible in a group setting. This may have made him feel lost, and there was an impression that he was searching for ideas of where to seek help during the interview.

> *… it was good the fact that [the facilitator] just gave me half an hour, forty minutes, an hour (...) On a one to one basis, I found that EXTREMELY extremely helpful (...) I suppose it's just tailored for you, isn't it? Where you can sort of discuss your financial problems you may have as a result of having a gambling addiction. The health element.. any consequences (...) as much as it's about you, the impact it's having with the people around you, the family element.* [Sandeep; lines: 397-414]

Sandeep describes approaching the facilitator as being "extremely helpful" in offloading about the impact his gambling has personally had in his life. In particular, he mentions the effect on his family, which is a concern for him. In contrast to Deva, Sandeep felt able to approach the facilitator for one to one time.

There were aspects of the groups that participants found valuable:

> *[You] get to (...) understand how your mind works (…) You come to realise how other people's experience of gambling is different but realise the impact it can have in your own life as well.* [Ajay; lines: 205-207]

Participants talked about the helpfulness of hearing other people's stories in the group setting. For Ajay and others, understanding their own patterns in relation to others seems to increase an awareness of himself. The impact of gambling seems to have been brought into consciousness by listening to others. Some participants directly suggest that undertaking both forms of therapy might be useful (see Section 3.3.3).

3.2 The Role of Culture

This master theme explores participants' personal experiences of their cultural background, including their views and perceived cultural views on addiction, mental health, gambling and their experiences of culture as a SA.

3.2.1 "What will they think?"

The following subtheme looks at participants' perceived stigmas and beliefs about gambling and mental health within in the SA community:

> *...gambling is not in line with my culture... there's a lot of stigma around it (...) not really being able to tell others, I feel pressures... I have this fear that if guests come (...) If they see any medicines around the room ask me what it is? (...) if I do tell them, they'll start making their own opinion, their own judgements about me (...) I think I'd be more depressed, more down regarding myself and (...) what's the point in going through all that making me feel like that.* [Ajay; lines: 337, 360-374]

Above, Ajay appears to feel that a stigma puts a certain pressure on him, which makes him actively hide mental health issues due to a fear of judgement, and believes that if people know about his mental health or gambling issues, he would be judged. Ajay does not seem to believe that there is another option than to hide it as the repercussion of them not understanding would be so much that it may lead to depression. He goes on to say that there is no point in leading himself to feel this way and implies that it is best to hide his issues, as nobody would possibly understand. However, the inability to tell others leaves him with a pressure to hide it, which sounds exhausting.

> *I don't think us Asian people (...) like to accept [any] form of therapy, do we? (...) It's just that stigma attached to it, isn't there? It's not just this, it's kinda any form of therapy if you ask me (…) it's just about ownership, taking ownership, for your problem and dealing with it, and accepting it and.. turning it around. Because we all kinda try to push it away, don't we?* [Sandeep; lines: 621-631]

Sandeep proposes that the stigma behind accepting any wrongdoing or any addiction is integral to how SAs deal with these issues. Going to therapy would be contrary to a belief that admittance would bring bad consequences and raise anxieties in some. He suggests that acceptance or "ownership" is pertinent to overcoming this stigma. I also noticed that Sandeep is connecting with me as a SA and looking for confirmation of the nature of SA culture with phrases such as "isn't there?" or "don't we?" I wondered if this was important to him in order to feel understood and whether he would have been as open with a non-Asian interviewer.

Aman offers us insight in to why there may be a stigma in the SA community:

> *[In] the Indian culture. There's the whole sort of (...) "what will they think (...) people might see me slightly differently. But again, I've not really opened up to that many people (...) They've got a certain level of respect for me for who I am.. I don't wanna tarnish that (...) whereas in other communities it might be more, you feel more comfortable talking about it (...) but within us, you know, this whole sort of shame on yourself, shame on the family, that plays a big part. So it's something you want to avoid if you can. I mean that's another reason why the individual sessions works better than whole group session (...). there is the whole sort of keep it behind closed doors, you know. You don't wanna be stigmatised as an addiction, a gambler (...) so if you can keep it quiet, keep it quiet.* [Aman; lines: 466-467, 337-350, 375-377]

Aman talks about a fear of being judged and seen "differently." He suggested that a stigma towards gambling in the SA community compared to others may prevent people from talking to others about their addiction. He suggests that his cultural background may have determined how comfortable he feels about talking about it to others, and suggests that it would be sensible to "keep it quiet". Others also allude to the ease in hiding gambling, compared to other addictions as there are no physical implications that others can detect. This has directly impacted him going to individual sessions, which has been discussed previously in subordinate theme 3.1.3. Aman described a SA tendency of families to want to keep issues such as addiction "behind closed doors" due to a fear of tarnishing the family name. This stigma seems to have determined that Aman will not disclose his issue to many people for fear of losing "respect". This may be seen as a specifically male issue of losing pride, which Samir discusses in the next segment:

> *... for an Asian man it's always dents to your pride (...) don't let other people think that you're smaller than them (...) at the end of the day if I was stood next to one of my cousins (...) earn the same money, have a similar job, have an amazing house, amazing life, but I put my hand up and said, 'gambling addiction', I'd be lesser to the person I'm standing next to. Just natural. I guess that's the cultural perception (...) it's harder for... Asian men to admit that they do have a gambling problem 'cos they are so arrogant and.. think that they can handle things themselves, stuff like that. But then to admit something like that, it's tough...* [Samir; lines: 513-520, 502-504]

This extract illustrates that Samir may want to keep his "pride" intact so that he does not seem "lesser" to others, including his family, similarly to Aman who did not want to lose respect. He also alludes to a perception in the SA community that to be successful, a man should have a good job, earn good money and have a good house. These are pressures that are discussed later. Interestingly, Samir also suggests that SA men are too "arrogant" to admit they have a problem, and that it was also "tough" for him to do so. This arrogance may develop from a need to appear superior to others by hiding problems and issues.

> *They'll probably take it to the next extreme and be completely the other side. So you know, stop this, stop that (...) sometimes not talking about it is a way for them to avoid it (...) There's not that right balance where we just sit down and talk about it properly (...) They prefer for it to go away, which obviously every parent would do. But it was something they didn't want the family or myself to be tarnished with.* [Aman; lines: 363-369, 378-380]

It can be suggested that Aman is implying that as his parents are of a different generation whereby they do what they think is right, by saying the buzzword "stop," but do not actually "sit and talk" through issues properly, as they were expected to deal with problems on their own. He describes it as an "extreme" and unstable behaviour. For Aman, the inconsistency could be tiring and cause for worry each time he thinks about broaching the subject. The attempt of families to avoid the subject and, perhaps not acknowledging it as a means for it to go away without difficulties may instil a notion in him that it is not okay to talk about it, and that they do not want to know. Perhaps it is due to the fact that they don't know how to approach it, means they hope it goes away before their families become "tarnished".

3.2.2 Struggle for Identity

The following subtheme explores the past and present cultural experiences of participants, and the struggles they experience with regards to cultural issues and differences, in particular, their SA heritage and living as a second-generation Briton.

> *... this is why the confusion happens, right? You live in one culture at home and you have another culture outside (...) she was talking about triggers in terms of normal things like, okay, watching an advert or something, or having problems in relationships and stuff, but one issue could be (...) the cultural differences.* [Deva; lines: 542-543, 789-792]

Deva and others encountered difficulties with identity as a child, possibly as a result of his parents not mixing with the community. This may have been partly due to their cultural difference and social isolation in a majority white town. Deva appears to feel that he missed out on opportunities that other children had which made it difficult for him to integrate. In some ways, his difference in appearance was highlighted to himself and others by the fact he did not have a chance to enjoy activities that others took part in. This may have left him feeling more defensive when his ethnic difference is pointed out. Deva and others talk about the conflicts of negotiating two cultures and how this has had an impact on how open minded and accepting he is to other cultures. Deva goes on to discuss his desire to be British:

I'm British, this is what it means to be British is I can look at anyone and I'm the same as you kinda thing. I've had to fight that stigma day in day out (...) It's just felt I should have, had a lot more (...) as a boy growing up (...) I think, insecurity in yourself that you belong here or not (...) When they see a brown face (...) I guess you're always thinking "what do people think of you?" [Deva; lines: 794-812]

It appears that Deva would like his culture to be considered as equal, and that people should not be categorised according to culture and ethnicity. He candidly talks about stigmas he has faced against his perception of feeling British. He believes that these issues of identity and feeling different could be discussed in the context of triggers for gambling alongside generic things which have been addressed in the groups. It appears that this has been exhausting for Deva and that he may resent this imposed difference in him.

Faraj's different challenges as a teenager came from a conflict between his family's religion and his own emerging identity.

When I was 19 (...) I made my decision and I knew who I was and I felt happier, at peace then (...) I think that's like one part of my life that's resolved (...) 'Cos I remember there were a few nights where I just kept thinking what am I doing, you know. Because I'm calling myself this, I'm drinking (...) I had a sexual relationship (...) contradicting myself in many different ways. So I had to solve that (...) then I decided I wasn't [Muslim] and for a few years, I sort of kept that secret. [Faraj; lines: 607-641]

For Faraj, confusion with identity seemed to stem from his religion. The contrast between his and Deva's story is striking, as Faraj feels somewhat resolved. In his teenage years, Faraj reported experiencing years of conflict, which resulted in him making a decision in order to put straight contradictions in how he wanted to live his life compared to his family. He appears to have felt unable to tell his family this decision, possibly due to a fear of disappointing them as the values and belief system appeared to be an important part of his family's identity. This fear may have caused Faraj and others to be less open about who they are and unable to share aspects their lives with their family. Through the process of solving his dilemma, Faraj claims he is much happier and "at peace" with himself.

Participants talk about the pressure to achieve and go into a career path, which was financially driven.

...I had the pressure of just achieving (...) I've been told I've got the opportunity and stuff and the thing is, they shape the way you wanna go, and I feel that's a bit unfair. I wasn't really given a chance to go like allow myself to kinda live and realise what I wanna do (...) course everyone has to work hard in any family, that's not a cultural thing (...) I think education is prominent in an Asian community (...) doesn't help if my Dads like Dad is a doctor as well (...) a lot of people say "oh it's a gene thing, oh Asian people are smart" but I think it's just because some of it is down to how you're brought up (...) I think that could've been part

of the thing where I was at uni... 'cos when I was running up to the exams, I hadn't gambled by then... [Deva; lines: 1015-1050]

This pressure seems to be due to a direct imposition from his first-generation parents as having the "opportunities" to be in the UK, which he believes is "unfair". One may suggest there was a direct attempt to make Deva feel guilty for not achieving this. He later states that this could have had a large impact on his gambling behaviour when at university. Deva does not seem to connect that being brought up in a particular culture may have had an impact on the way he lives his life, as opposed to just being usual pressure from families. This contradicts the fact that he believes that the Asian stereotypes of being hard-working is particularly cultural and that there may be an emphasis on education. His father's status as a doctor upholds this stereotype he has faced, possibly adding to an external pressure. Perhaps from my questioning, Deva feels as though I am dismissing the fact that other people have issues they need to deal with as a result of family pressure. He also addresses me as a culturally similar person who he may presume will understand.

So I wouldn't wanna do nothing to disrespect my culture (...) but [culture is] not something that was so important to me. If it wasn't an issue for my family (...) it wouldn't be that big a deal for me (...) I wouldn't say I'm completely ignorant, but I don't totally understand all the details of the background (...) There were certain things that they really focused on, like these festivals, these days. Don't eat meat for this period of time. [Aman; lines: 290-293, 322-328]

Aman discusses the importance of following his culture to respect his family. He goes on to state that it is not too important for him and describes a lack of knowledge of certain customs and the meaning behind them. I wondered how it must have felt for him to do things for his family that he does not necessarily believe in or understand. It seems as if it was more important to please his family or go along with it than retaliate against these impositions. Perhaps he did not feel pressures and his lifestyle may have meant that this was possible in order to appease and keep the peace. For others, like Faraj, this did not seem possible as his parent's religion may have been more imposing on his lifestyle:

I think pretending is what hurts (...) I still don't openly admit that I drink to my sister and my Mum (...)But, being at this home now that I'm living in now with my sister (…) It's completely open, I'm basically my own person now. [Faraj; lines: 659-662]

Faraj describes his experiences of being closed with family members and not being able to admit fully who he is to his Mum in particular. This seems to have brought about emotional pain as he states that it "hurts" not being open. To relieve himself from these pressures, Faraj seems to have found it necessary to physically remove himself from living with his Mum. It can be imagined that being away from the 'big brother eye' may make him feel less guilty.

...my sister said, they're proud of me 'cos I'm being responsible and taking it [seriously] (...) I thought to myself that I'm actually taking a real big step. [Faraj; lines: 308-310]

The way Faraj and others talk about pleasing their sister indicates the importance of their support and pride in them, and appears almost motherly. Approval from sisters in particular seems to be pivotal in Faraj feeling happy with himself.

3.2.3 The Burden of Family Knowing

The following subtheme explores how participants make sense of their parents' and family's reactions to discovering their gambling issues, and subsequent internal pressures this may cause within the individual. This was central in most of the participants gambling stories, highlighting its importance.

...they are pretty worried about my future (...) the gambling has caused a lot of distress within my whole family and parents are more distressed than me... [Ajay; lines: 403-425]

Ajay's family seem to have internalised his distress as their own and concentrate on concerns for his future which may have had an impact on how he views himself. Ajay may be worried about trying to overcome his difficulties, which may be enhanced by the distress his family are reporting. This could leave him with feelings of guilt, an overwhelming sense that it is too much to overcome, and that he let his family down.

... [my brother] only wanted to take in ... from a negative point of view what I have done, (…) broke the family up, family names not very good, we're all successful, what's happened to you? (...) [Mum's] very devastated in terms of the impact it's had, on the family.. and her exact words were "I didn't think you'd, you know, you'd do this, why did you?" (...) she said just ensure that you keep away from these negative thoughts. [Sandeep; lines: 436-473]

Sandeep's brother appears to have been unsupportive, evidenced by the way he reacted angrily and did not understand. He seems not to have comprehended why he would jeopardise his success. Success is a theme that has come up in theme 3.2.2 as a cultural value to aspire to in SA men's upbringing. This is one of the things Sandeep recalls as being a factor in his brother asking him questions, which might imply that he feels judged for not being successful on account of failing by gambling. The emphasis seems to lie on the difficulties he has created with his family. I began to sense a focus around problems caused in the family without consideration of the individual, which made me wonder how participants are supported in the short term. Additionally to this feeling of vilifying the gambler, Sandeep claims that his mother has asked him to "just" keep away from gambling which implies that it

should be relatively easy to do. People may not feel like they can accept it as a viable problem to seek help for and should be able to stop easily. It also appears that his Mum's reaction may have made Sandeep feel guilty by announcing that she didn't think he could be capable of these things, and points out the "devastation" caused in her and the family, as his brother has already pointed out. Sandeep also reported that his brother took a more aggressive stance and mentioned "the family" name which implied the wider family, and not just his immediate family. This is guilt seemingly in additional to his own. The disappointment from his family would have likely been hard for participants and a contributor to hiding gambling-related difficulties due to a fear of disappointment and disapproval.

> *... the culture looks at it from a financial perspective, like "why are you chucking away money?" As opposed to "why are you chucking away your mental health?" (...) That's what it always comes down to, not the wellbeing of your brain.* [Samir; lines: 197-200]

Furthermore, Samir and others describe their family and culture as seeing the issue primarily as a financial concern, and equate this as being a cultural point of view. Above, Samir believes that this view neglects the individual's wellbeing and mental health. This is another example of the misunderstanding of the issue of problem gambling and potential trivialisation of it.

> *I'm lucky I've got a very, very supportive family. Although, my Mum and Dad found out through coincidence. And it is tough to talk to them about it. They think that I've just stopped and it's as easy as hitting a nail in to the head and you stop. But it wasn't, 'cos I've relapsed at least four or five times (…) So I took a decision not to tell them the last time that I relapsed. And, they don't know that I go into therapy...* [Samir; lines: 70-75]

Samir states here that his parents are very supportive, yet he paradoxically proclaims that he is not able to tell them his struggles about his gambling illustrated by the fact they found out coincidentally. He struggles to explain the difficulties of stopping and presumably cannot take their trivialisation of it, resulting in him making a decision not to discuss his relapses with them anymore. This could be due to concerns for their health and for them not to worry or because he does not want them to think badly of him.

3.3 Experience of Learning through the CBT Framework

The following master theme explores participants' experiences specifically through learning within the CBT context and how they understand their PG. this included their experience of learning CBT-specific strategies, how they experienced the role of culture in therapy and how their experiences led to reflections post-therapy.

3.3.1 Experience of Learning CBT Strategies

During the interview, each participant recalled specific CBT strategies for their gambling behaviour, as well as learnings from the therapy process. Participants experienced both helpful and unhelpful aspects of the learned CBT techniques, in order to address their gambling issues. Below, Deva provides an experience of behavioural strategies learnt during CBT:

> *...in the first week they kind of tell you no money and no access equals zero gambling (...) the money situation I addressed, but obviously if you're a gambling addict you (...) find a way of getting money (...) one of the things I didn't do was block access to my laptop and phone (...) having flash cards which said eight positive and negative reasons for gambling. So something simple like that, if you can read that every 5 minutes, every day then (...) you kind of drilling into your mind why you shouldn't gamble...* [Deva; lines: 62-94]

Deva and others found it difficult to adhere to the strategy of no money and no access, and was unable to completely withdraw his access, thus illustrating the nature of gambling therapy. However, he did manage some strategies and this may illustrate that Deva seems able to accept help for his gambling and is committed to change. Furthermore, Deva appreciated the effectiveness of the cards in keeping the bad things about gambling at the forefront of his mind as the main intention of it. The following extract describes a theoretical learning from the CBT for gambling model:

> *And once you've lost, you're gonna chase, chase if you say you're gonna go out for a couple of drinks and then you gone past that stage and then you just keep going on until sometimes you just go overboard [and go to] A&E or pumping their stomach (...) it just spirals like that.* [Raj; lines: 205-209]

Raj describes the process of chasing losses when gamblers only remember wins and try to retrieve what they lost, but then try to win more, which Raj tries to emphasise is perhaps not rational. He rationalises a short term win in the moment and acknowledges the complex struggle in a gambler's mind about the long term impact. He then illustrates it using an alcohol analogy, possibly in an attempt to normalise the behaviour or explain himself. It may have also been an approach used by therapists in order to explain gambling behaviours to their clients, which seemed to have resonated with participants to help understand their issue. This has been a strategy used by others, perhaps as a way

to make sense of their difficulties by comparing it to a problem which has been established in society. He then goes on to say it is not done "intentionally" which may be a perception he has struggled with from others, and that may have come up when his family reacted to finding out (see subordinate theme 2.iii).

The following extract describes the CBT applied to participants' gambling activities:

> *... [CBT is] just how your mind works and (...) I've never like experienced such a thing (...) So it's a case of realisation of the feelings that occur because your desire to gamble and then it's a case of okay, how do I control these feelings (...) you think an addiction is just like okay stop that (...) don't [take out] money (...) it's like kind of went beyond my expectations it's like trying its having a better understanding how you.. how you process things.* [Deva; lines: 23-25, 289-291, 470-474]

Participants, such as Deva above, emphasised the knowledge of how the "mind works" and learning how to control or manage thoughts, behaviours and feelings. For Deva, it seemed to be something poignant as he had never "experienced" gambling specific therapy before. Many participants enjoyed the fact that they were gaining a better understanding of themselves as an important learning from therapy. Deva appreciated that he learnt that it is not as easy as stopping, which may have been a perception he had before, as seen in subordinate theme 3.2.3.

Another learning many participants encountered was the meaning represented by attending therapy. To begin with, many felt that it was difficult to accept that they had a problem with gambling.

> *The fact that I'd admitted that (...) I've had a gambling problem and I'm going into therapy [laughs] The whole thought of that itself, I knew what it was about and I knew it was going to help me, but the fact of the matter is.. I didn't wanna be a gambling addict.* [Samir; lines: 261-264]

Above, Samir talks about it being hard to admit he's addicted to gambling and that going to therapy is a symbol of that label, despite knowing that therapy would be beneficial. Perhaps this fear of having a label stems from a stigma him and others perceive of gambling in society. A perception that if he admits it, perhaps he has failed at not being able to deal with it by himself. Perhaps this judgement of the other group members comes from a stigma towards others who have a gambling addiction, which is ironically the stigma he fears. The fact that Samir laughs is perhaps an indication that in hindsight, knowing the value of therapy, he feels silly that he hesitated.

3.2.2 Experience of the Role of Culture in Therapy

The following subtheme explores participants' experiences about how practitioners addressed culture in CBT for gambling, when working with SAs. It seems as thought they contemplate the appropriateness of addressing culture in group therapy:

> *Because those are triggers. And they're things that have led to.. it's like I've not addressed this issues (...) and I'm probably gonna live with it for the rest of my life (…) they should (...) understand the second generation thing (...) it could be a causality...* [Deva; lines: 688-690, 825-826]

Deva expresses that his cultural background should be taken into account because of its potential to have been a cause or trigger to his gambling problems. He appears to be resigned to the fact that his cultural issues may be a factor that contributed to his gambling and something that he will live with forever.

Sandeep seems to argue that culture should not be addressed in a group setting as it is not practical as some will not be relevant for other cultures.

> *I'm gonna say no, at this moment (...) if there's a lot more South Asians.. in the group, then possibly, but then are you trying to dilute the group a little bit. .* [Sandeep; lines: 655-657]

When asked if it's appropriate to talk about culture in an individual setting, Sandeep goes on to say that it can focus on the individual impact that he may not be able to relate to in a group. He goes on to state that you could get into the "nitty gritty" of it, implying that gambling is a superficial topic, and understanding its impact and cultural significance is important, as well as its impact on the family. He does not necessarily believe this means just the cultural background, as this may just be another factor in someone's life. The declination at the start may indicate Sandeep did not feel like it was plausible until I directly asked him about an individual setting.

> *Yes, then I would possible say (...) what sort of an impact it's had to ME. What sort of impact it's had to my family, as a culture and so forth. Then you'd have to really, get into the nitty gritty of it.* [Sandeep; lines: 664-667]

3.2.3 The Aftermath of Therapy

This section explores advice for others as formulated by SA men as a result of reflecting on their experience of going through the process of CBT for PG. It appears as though their experiences have thrown up advice for other people thinking about attending therapy for their PG and people who provide gambling therapy services, particularly the NHS. To begin with, reflections that participants provided as possible advice to prospective attendees of therapy, will be explored.

> *...it is obviously 95% is your own willpower and obviously depending on what your goal is out there at the end of it, it depends how strict you are about it.* [Raj; lines: 352-353]

Raj talks about a need to want to stop gambling before people go to therapy, and that potential attendees have to be strict on themselves. These aspects have affected participants' experiences of being in CBT. Raj seems to be suggesting here that if the goal when entering therapy is not to give up gambling, then this will have an impact on how strict one is on undertaking the strategies learned during therapy, and that it is their prerogative to use "willpower" to monitor their gambling. This may, in turn, have an impact on the effectiveness of therapy. It strikes me as interesting that Raj knows what it takes to get the most out of therapy, but provides us with evidence that he does not want to take the responsibility and be "strict" on himself, since he dropped out after four sessions. It seems as though he is aware of his decision.

> *I've gotta learn from mistakes from last time and (...) when you get the homework sheets and stuff, actually do it (...) because at the end of the day, if you don't block your access (...) [you're] keeping (...) that door ajar kinda thing (...) for any possibility for it to happen again (...) I feel if it's something you could do on a weekly basis it would be amazing but obviously NHS can't fund that or (...) it's not plausible (...) I found as soon as I stopped going (...) when something triggered (...) [the skills I learnt] wasn't at the forefront of my mind (...) it was just frustrating that I forgot the skills I learned.* [Deva; lines: 86, 487-496, 70-82]

Deva had previously undertaken group sessions and talks about learning from his "mistakes" during those sessions where he claims not to have read the material. These mistakes may need to be realised in a previous experience of therapy before being able to move onto the next stage. Following on from this, Deva and others who attended group suggest that services should provide the option of attending more than one therapy programme, or regular catch up sessions. They suggest that this may allow people to get used to the process of therapy and have space to learn about the need to put things into place, by overcoming lapses, doing homework, and keeping concepts learnt at the "forefront" of the mind. This may explain Deva's frustration. He reported to understand that this ideal solution may not be plausible in the current NHS climate.

The following extracts focus on the resulting reflections on the role of services in promoting psychological help in SA men with gambling problems.

> *... 'cos [SA men are] so proud to come forward and admit it, it's like you have to go out there and drag them out, and physically shake it out of them, and that's not gonna happen. If there is awareness, if there was (...) somewhere for actual South Asian men to actually go and talk.. about this problem, then maybe [they would] (...) I know South Asian men need help.. I'd be, willing to stick my neck out on the line and try and do something to get these men to actually admit the fact that they have a problem.* [Samir; lines: 525-535]

Samir states that it is important for the awareness of services to be addressed in SA communities as it is difficult for SA men to step forward due to issues of pride as discussed in subordinate theme 3.2.1. He becomes impassioned about this issue, and talks about wanting to help in the community and to show people it is not a weakness to admit you have a problem; perhaps something Samir has learnt during his own journey. He may have felt that SAs have been side-lined, but are entitled to get the same help as anyone. This view is in line with participants feeling British and some who have felt judged for being different (see subordinate theme 3.2.2).

> *... if you can promote [one to one sessions] a bit more. Because I didn't know about (...) the ones that are on the NHS, only the ones you pay up to a hundred pounds a session for. And again I guess it's getting that balance right 'cos I guess if every single addict came to the NHS and said, "I've got this problem" (...) there'd be quite a lot of people coming through, and probably not a long, not enough people to deal with it (...) Most people would be more comfortable talking in that secret room (...) [I] probably would have gone sooner (...) I would have been a lot less sceptical about [it]...* [Aman; lines: 479-490, 417-418]

Aman felt that the individual sessions should be promoted, particularly for those who would feel more comfortable seeing someone in private. The idea of speaking in a room with others felt too scary for him, but for a while, he was not aware of another option and this prevented him from experiencing therapy earlier. He states that he only knew about sessions which cost lots of money perhaps indicating perceptions of private therapy portrayed in media as encountered by others (see subordinate theme 3.1.1.) There is once again, a concern that the NHS will not be able to provide an individual service to everyone that needs it. He states that if he had known, he would have gone sooner. Aman also suggests that had he known about the usefulness of therapy, he would not have been as sceptical about attending.

4. Discussion

This section discusses each theme alongside previous relevant research findings. The main finding will be emphasised, followed by a reflexive account of the process, limitations and recommendations.

4.1. Experience of Psychotherapy

Previous experiences of therapy appear to play a large role in people deciding what mode of therapy to undertake, and in instances of bad experiences, how long it might take to come back to therapy. Higher rates of drop-out in the first few sessions of group therapy have been found (Echeburua, Baez & Fernandez-Montalvo, 1996; Jimenez-Murcia et al., 2007). Only one participant had not encountered any type of therapy before and was the only person to drop-out after expressing ambivalence, in contrast with participants who had experienced therapy before and talked highly of its value. This may be due to feelings of shame, having to admit problems to strangers or a worry that people may judge. A realisation that they are struggling more than previously admitted, could lead to denial, and a sense that they are in a better place than others. This may also lead participants to prefer individual therapy. Participants who continued to go despite feeling uncomfortable reported to feel more comfortable as the sessions progressed. This can be supported by Jimenez-Murcia et al.'s (2007) study which found that drop-out rates decreased the more sessions that were attended and more significantly after the fifth session during group CBT for PG. There may be a link between the level of previous therapeutic experience, particularly individual therapy, and the level of openness and acceptance of issues and cultural histories. This may be described using the change model (Prochaska, 1992) which states that people generally attend therapy several times to overcome addictions by increasing motivation and acceptance each time, corresponding with the fluctuating clinical trajectory of PG in the form of frequent relapses (Slutske, 2006). This study suggests an extension of this model to gambling, also described by Petry, Stinson & Grant (2005).

A major concern for participants seemed to be people knowing they were attending therapy, which led to many choosing individual therapy due to the importance of confidentiality and a guarantee of secrecy. There seemed to be resistance in attending group therapy due to a fear of judgement and stigma from others, and from others outside of therapy discovering their attendance possibly through a chain of connection of people. Self-stigma has been found to increase with the expectation that others will judge them negatively (Hing & Russell, 2017), leading to an avoidance of help-seeking, until the last resort, facilitated by the relative ease of hiding PG (Scull & Woolcock, 2005; Bond et al., 2016). Findings reflect the underrepresentation of SA males within PG services as well as in other mental health settings. This preference of being seen in a secret setting and reluctance to seek help for fear of shame, pride and denial has been consistently found in PG reviews of help-seeking (Pulford et al., 2009; Tavares, Martins, Zilberman, & el-Guebaly, 2002) and builds on semi-structured interviews with 3 female and 7 male Asians from Australia

regarding access to healthcare (Wynaden et al., 2005). However, it was not clear from which part of Asia participants were. This study more specifically builds upon the work of Wanigaratne et al.'s (2003) qualitative study that found Asians (including Indians) to have fears about confidentiality and the consequence of having drug user status revealed if outside help was sought. This study adds to previous findings of confidentiality fears and being revealed as a drug user in SA populations who help-seek less (Pearson & Patel, 1998). On first impressions in the group, there seemed to be judgements of other members and not thinking they have a problem like *them*. Ironically, this is the very perception from others which made them feel self-conscious or too proud to disclose their difficulties and has been utilised as a strategy for men to protect self-esteem as hypothesised by Perlick et al. (2007), as influenced by 'masculine ideology' and 'mental health stigma.' Perhaps it is this conflict that maintains a reluctance to expose themselves, as admittance would lead to a fearful acceptance of their *label* to strangers (Horch & Hodgins, 2015) and discredit their desired self-concept (Snow & Anderson, 1987). This initial hesitation or denial in the group, in time, led to an acceptance and a feeling of becoming part of the *team*. If members drop-out early or have a bad experience, then they may not experience this progression, increasing the risk of not accessing further support.

Although some may have felt more open as the group sessions went on, there was a consensus that individual therapy would take into account individual circumstances and contexts (i.e. the impact on their family, work, social life) and that individual triggers to their gambling could be discovered. Many expressed that their needs and experiences were not acknowledged as individual to others', implying that their group sessions did not sufficiently target their personal gambling-related challenges. This may have left them feeling less heard as an individual with personal experiences, seen as irrelevant or unimportant in a group setting. Participants recognised the value of both group and individual therapy. Group therapy was deemed as useful (three out of four stopped gambling compared to one out of three who experienced individual therapy). However, those who still gamble have previously had group therapy, which may not have successfully targeted deeper rooted issues that may impact the revolving door pattern of problem gamblers (Prochaska & DiClemente, 1986). Therefore, looking at the format of the most recent or current therapy may not be useful in determining their effectiveness. For this project, the value had been placed on the experiences of individuals', which also encompass their understanding of the usefulness of the format of their respective therapies, irrespective of their perceived outcomes.

Participants who experienced the groups sought further individual work after the group, such as Sandeep, Deva and Faraj, illustrating the realisation of an importance for participants to address difficulties in addition to gambling, including culture. This may be being realised during current or previous individual therapy, including from external agencies, highlighting that these concerns are not fully being discussed in the group therapy. This may be due to not feeling fully understood, and a feeling that there is more to explore and work on, perhaps as a result of opening up

during therapy. This begs the question of group therapy being holistic enough to understand individuals in their context including gambling specific consequences.

The importance participants attach to individual therapy is illustrated by the fact that most (all but one who dropped out) participants said specific factors in SA community would be more suitable to explore in individual therapy, and that this would be relevant to other issues. Though participants seemed to drop-out, this may have been explained by the need for cultural sensitivity or more individualised therapy in this population who may be more likely to drop-out prematurely. This may be more necessary in individual therapy due to the vulnerability that might be experienced when distressing personal issues arise not covered in groups. We cannot assume this is due to the therapy itself. Individual therapy may be particularly difficult for SA men who may not be used to expressing themselves to others or wary of judgement that might be felt from opening up.

There seemed to be a general preconception from participants that therapy is seen as a lavish expense rather than something provided by the NHS. Perhaps it is perceived as a luxury which *ordinary* people do not use. This may be an unrealistic and glamorised portrayal provided by films and TV, making it seem abstract and not disorder-specific. This apparent unaccommodating notion of therapy may have delayed help-seeking. Preconceptions of therapy may have implications for whether people have accurate knowledge to make an informed decision about attending therapy. Raylu and Oei's (2004) review on SE Asians also found that one of the reasons that problem gamblers were less likely to seek help was a belief that services were under resourced.

A valuable experience for participants seemed to be the realisation that they are not alone in their difficulties and experiences. Experiences from one participant who felt judged by the therapist led him to drop-out. Bad experiences such as this may leave a client feeling unwilling to come back to therapy as they do not view it as different to other judgemental experiences in their life i.e. a perception that mental health professionals may view them in a negative light due to a public perception that gambling issues occur as a result of personal shortcomings and personal responsibility (Feldman & Crandall, 2007) as found in 30 interviews illuminating the psychological barriers to help-seeking. The group dynamic seemed to give participants different perspectives to facilitate self-awareness and put personal struggles into perspective and to give hope. Most who attended group sessions returned. This option seemed to provide stronger motivation and admittance of their issue as well as consolidating information, which would address some of the frustrations about not reading the materials or consistently applying the knowledge. This has often been found in other addiction settings, represented by the pre-contemplation stage (Prochaska, 1992), and may create the readiness needed for individual therapy.

4.2. The Role of Culture

A pressure to achieve was found in second-generation SA males that may have been filtered down from parents. This supports the finding from interviews with Malaysian problem gamblers whereby financial gains have been linked to self-esteem, highlighting that the loss of money may decrease this and lead to negative self-perceptions (Choong, Loo & Ng, 2014). This is perhaps induced by higher levels of stressful experiences compared to first-generations. Admittance of gambling issues may cause a sense of failure (Baxter et al., 2016) and betrayal of their parent's trust. The finding about being told about the opportunities of being in the UK may have been experienced by others, which strengthens the inability to part ways with the older generational norms. Being brought up by a generation that may think differently about owning up to or dealing with issues, might explain why participants find it difficult to disclose. It appeared that participants felt *stuck* between two generational cultures and their differences in approach to seeking help. There seems to be a belief that for SAs, it is in their best interest to keep their issues behind closed doors and external from the community in order not to risk bringing shame to the family (Das & Kemp, 1997; Scull & Woolcock, 2005). This includes going to therapy and risk divulging issues to the public, or to risk besmirching their izzat (Wanigaratne et al., 2003). Masculinity seemed to be an additional hidden pressure in SA men, which is evidenced by greater rates of male SA problem gamblers and connotations with strength, willpower and pride for which seeking help could be considered as an inability to be independent and self-sufficient (Addis & Mahalik, 2003). This study provides more evidence for increased shame with admitting vulnerability found by many studies into the barriers to help-seeking for gambling in men when compared with women (Baxter et al., 2016; Rockloff & Schofield, 2004). This could be seen as a perception from traditional male roles in the SA culture to preserve respect and pride, which has been found in other collectivist minority populations with gambling issues (Kolandai-Matchett, Langham, Bellringer & Siitia, 2017). All participants were left with an inability to share the full truth with families, also illustrated by the fact that they were unable to tell their parents about their difficulties with gambling. Interestingly, all participants' families found out about their relatives gambling issues by accident or when the participant was desperate and needed money to bail them out from their debt i.e. similar to hitting 'rock bottom' which was described by Evans & Delfabbro (2005) who conducted telephone interviews with PGs who had previously accessed help. Many participants pointed out that the ability to hide is made easier by the fact gambling is less obvious for others to see, and made more dangerous by an added financial detriment. Cultures which idolise success and money might make them more vulnerable to try gambling for quick success to prove their worth.

In accordance with previous research, participants in this study may have separated from their ethnic identity. Second-generation immigrants have been found to identify as British more than first-generation Indians and Pakistanis, though there was a sense of feeling different to white British, which supported further by this study and may explain the lack of cohesion felt between two worlds in the UK (Hutnick, 1991). A deep exploration of culture seemed inhibited due to a strong wish to be considered as British as their SA side may have been previously hidden

to assimilate. This is in contrast to previous finding that have found second-generation SAs to prefer a hyphenated identity (Lalonde & Giguère, 2008; Modood, Beishon & Virdee, 1994) Therapists thus need to assess the interaction between these two parts in negotiating their identity, autonomy, and relationships alongside gambling negotiating behaviours. This could fall in line with the initiation of gambling problems in men, which have been found to originate in adolescence (Merkouris et al., 2016; Toneatto & Wang, 2009). One participant in particular felt that a cultural dissonance made it harder for him to integrate with other children as his parents did not adapt to the host culture. This is in line with previous research which has often found non-integration to be the choice for immigrant parents of children who later manifest psychological issues (Anwar, 1998; Koplow & Messenger, 1990; Minde & Minde, 1976; Shaw, 2000).

Perceptions constructed from living through a conflict of identity seem to have cultivated passionate beliefs in participants that everyone is part of the same British culture, and that no subculture is superior to another. Bringing up differences within participants with direct interview questions concerning cultural identity may have brought their guards up as this characteristic is essentially being singled out, which they have "had to fight" throughout their lives. It has been suggested that research participants often struggle to talk about their thoughts and feelings (Smith & Osborn, 2008). Therefore, the analysis has considered what the participants have and have not said. Some participants did not appear to think about culture being a potential factor in their life or connected to gambling. For some, this seemed to be a dismissal of cultural issues, despite having mentioned past influences. These strong beliefs may also indicate that they have had experiences with identity they did not feel able to discuss with me. It has been interesting to note experiences of identity with respect to participants' cultural backgrounds and their social embeddedness in British culture, which was unexpected.

Only one participant described himself as religious. It has previously been found that religion may play a strong role in how people experience and give meaning to their life (Anwar, 1998). Most others talked about respecting their culture for the sake of their families, reporting a sense of ambivalence towards traditions, suggesting that they were doing it to help keep the peace. It could be stated that religion is interlinked with culture and experiences with culture may have also incorporated a religious element among others. The finding of one participant from a Muslim family is consistent with Ali and Aboul-Fotouh's (2012) finding that second-generation Muslims in Western societies are less concerned with their SA collectivist values. Furthermore, it has been found that religion is considered as low in importance in second-generation Hindus and Sikhs (Welte et al., 2017). This supports a finding that if personal values including religion do not match between generations, this can leave those who 'defected' feeling isolated and lead to an increase risk of mental health issues (Sonuga-Burke & Mistry, 2000; Asvat & Malcarne, 2008). The lack of strong religious following in this subgroup and its lack of potential to fulfil a protective role needs further investigation.

There also appears to be a lack of understanding about what is helpful in tackling PG from parents i.e. bailing them out may prolong the difficulty if problem gamblers are continued to be *saved*. There may be an expectation for the problem to go away quickly, and a preference not to talk through it. The possible attempt of families to avoid the subject and, perhaps not acknowledging its extent may instil a notion in participants that it is not okay to talk about it, and that they do not want to know, leaving them without developed coping strategies. Once acquainted with the issue, there seems to be a primary concern from the family of the impact amassed upon themselves, including their own distress and jeopardised success without a regard for the individual's mental wellbeing. This may harbour guilt for having *created* the problem. Families are described as concerned about the financial repercussions and may see gambling as an indulgence. *Throwing away* money would be seen as contrary to the demand to achieve. This can enhance attributions of self-blame in problem gamblers as a medical rationale does not hold the same compared to substance addiction (Dunn et al., 2012) as they have already been found to feel at fault due to a perception of weakness and lack of self-control (Carroll et al., 2013; Hing et al. 2015; Horch & Hodgins, 2008). These parental and family ideas appear to contradict the learnings gained from the problem gambler (see section 3.i) through CBT therapy that leaving an addiction is not as easy as self-control. This may have initially prevented participants from seeking help and feed into the loss of pride and a feeling of failure reportedly felt by participants prior to therapy upon seeking help (see section 1.i). Lower levels of family support have been found to be a risk factor for gambling in adolescents (Hardoon, Gupta & Deverensky, 2004). Previous qualitative research has emphasised the significance of family emotional support for SAs (Bowl, 2007; Netto Fancy, Lomax, Satsangi, Smith, 2003; Tabassum et al., 2000). Therapists therefore need to be aware of the lack of support and therefore potential isolation felt when handling dual identities, as this may leave them remaining unheard. Although family have supported participants into therapy, this support may not be emotional (and empathic) in nature which is most important in recovery, and that SAs definitions of support may be more linked to being physically present. At times, participants spoke about not being able to address difficulties and share parts of themselves, which was contradictory to their feeling of being close to their families. There is a paradox that the culture is close and supportive, yet most feel unable to let family members down or talk openly about problems or admit that they are seeking help from therapy. Following on from this, many participants expressed a need for experts to understand, not solely to advise and teach. This may have been in order to replace the dearth of understanding from their family or to fulfil the need of having to tell someone who will not judge them or undervalue the issue. All but one participant (who only recently moved out) were currently living with their parents. It is possible that living with parents (a cultural norm) can enhance pressures of having to live a certain way, prolonging feelings of identity crises, distress or hiding due to shame and therefore avoidance of help-seeking. An interesting finding during the analysis was the supportive bond between siblings, most notably between sisters and the problem gambler. Perhaps it is approval from a family member that takes the edge off not being open with parents. This is something that really resonated with me, as I am close to my siblings, and this may have been as a result of being connected in our common difficulties of being between two cultures.

This study supports a notion that growing up with experiences of people pointing out their ethnic difference, seems to have contributed to participants feeling boxed into a certain category. In addition to this, their parent's experiences during acculturation and their own strategies used to assimilate could have an effect on a child's ability to create a dual identity and their subsequent feelings of belonging. This may be further impacted by the levels of acceptance towards their child's way of living during their adolescence. Gambling may be used as a coping mechanism, previously found as a result of social disconnection and family conflict, which are relevant to experiences in the participants of this study. Blaszczynski and Nower's (2002) Pathway 2 for 'emotionally vulnerable' people may help us to understand the complexities of culture and individuals and their journey to problem gambling.

4.3. Experience of Learning through the CBT Framework

Overall, participants appeared to have gained a benefit from integral CBT strategies and concepts, as well as contemplating their whole experience and making observations on further knowledge acquired. Contrasting accounts of the restricting money strategy showed that some are more willing to adopt them. It could be suggested that how willing participants were to apply the techniques was indicative of how ready or motivated they were to engage with therapy and therefore how effective therapy was likely to be. Levels of commitment to change during therapy may indicate whether someone will adopt the strategies, which may be mediated by previous experiences of therapy (Petry, 2003).

In CBT, one of the fundamental aims is to become more aware of cognitive and behavioural processes that maintain unhelpful behaviours and beliefs within themselves. Learning that therapy was more than restricting behaviour went beyond participants' expectations and may have alleviated the idea that they should rationally be able to stop the behaviour, a perception problem gamblers have been found to hold (Hing et al., 2016), which seems to have been the reported expectation from families once they became aware of the issue. Previous findings have found that problem gamblers can be self-deprecating and place blame on themselves for not being able to stop. The comparison of alcoholism analogies appeared to have aided self-coping by normalising the addiction and to counteract the shame and embarrassment they may have felt. There may be a lack of parental knowledge from first-generation parents who are from SA countries, such as India who may not understand its prevalence and impact as it is lesser known in their original countries' psychiatric system (George, Kalluvagalil & Jaisoorya, 2014). This familial lack of understanding may have been passed down to participants, and a new found learning that it is not easy to stop may have gone some way to reduce their self-stigma, which has been found when individuals internalise stigmatising social attitudes (Corrigan & Watson, 2002). There were implications about how well-known gambling therapy services are as participants advise that these services should be more available and accessible to people. It is possible that the

pressures talked about previously had prevented participants from attending therapy sooner as shame had led them to wish to handle it on their own as found in Suurvali et al.'s (2009) literature review into help-seeking barriers, mostly until they had been financially cornered. Following on from participants' suggestions that pride and stigma on account of their ethnic status that may prevent SA men from going to therapy, some participants suggested that advocates such as them can act as a conduit between two cultures to provide an understanding to the SA community. Perhaps this suggestion by participants results from feelings that this would have been helpful for their own progress, and therefore recognises its need for others to feel heard.

In response to the sense of failure of not having battled the issue themselves, a powerful hurdle during therapy was admitting that they had a problem. This may have also confronted their self-worth as a man, which has made it harder to accept. Initial judgements of other group members may have been a projection of their fear of judgement onto others for self-preservation i.e. cognitively distancing themselves from the stigmatised group (Link, Yang, Phelan & Collins, 2004) to protect their self-image. Consequently, this resistance to therapy would have an impact on the initial engagement or success of therapy. Advice given appears to focus on warning prospective clients to put in the effort and take responsibility in order to affect change in their gambling behaviour (see section 3.iii). This fundamental teaching of CBT seems to have been grasped by most participants. In line with the acceptance participants reported to have learned, many gave a warning to prospective attendees that they need to *want* to go to therapy. Participants equate it to having willpower, but it may be supposed that therapy for gambling is a process, and that attending more often will have a stronger affect. Group members suggest that people should be given the option to continuously attend the group to help keep information fresh, for people to learn from their mistakes and to deal with highly likely relapses. This may serve as a stepping stone to becoming readier and accepting of therapy in a contained environment, especially since relapses have been found to exacerbate deep shame (Hing et al., 2016).

Throughout the analysis, there was a sense of confusion and resistance against wanting to be defined as having a cultural difference, conflicted with a desire to feel understood in therapy by taking into account their culture as well as other characteristics. Perhaps this is a consequence of feeling the need to hide parts of their selves to feel accepted. Participants seemed particularly defensive, possibly as a result of me labelling them as 'South Asian' and not seeing them as a 'British' person. Some seemed to defiantly believe that culture was not an issue, and some were not willing to discuss it in detail, indicating a resentment of a difference in culture. Participants conversely understood that these issues are specific to the SA community. Perhaps they are emphasising that it should be looked upon with the same importance as other issues, as potential causes or triggers to the gambling behaviour. The consensus was that the exploration of these factors would be more suitable in individual therapy where it would be possible to explore all facets of the person. This holistic view is in line with the philosophical teachings of Counselling Psychology, and may not fall fully in line with pure CBT, which is often regarded as not considerate of the complete history and

background of an individual and remaining symptom focused (Hays, 2014) as illustrated by the manualised group CBT experienced by participants in this study.

Some participants also curiously recognise the limits of healthcare funding and question the plausibility of the request for greater support, supporting a finding by Raylu & Oei (2004) that this may make problem gamblers less likely to seek help. People seem to be aware of the restrictions of the NHS system, illustrating underlying perceptions of understaffing, under-resourcing, and perhaps a lack of focus on psychological services. Acknowledgement of a lack of resource, perhaps absorbed by the media narrative, may have indirectly prevented people from discovering the existence of these services, thus adding to the already complicated process leading to this population in obtaining appropriate help.

4.4. Main Findings

The results from this research provide the first qualitative account of second-generation British SA men and their lived experiences of CBT for PG. Main findings show that SA men may not understand the concepts of different types and modes of therapy, and consequently arrive into services late. This may be compounded by their status as SA, which can serve to inhibit their desire to *expose* themselves as problem gamblers (due to stigma) or as failing to overcome the problem themselves and without help (which has connotations of bringing shame to the wider family, and *failing* as a successful male). This is evidenced by some of the immediate family's desire to hide and deal with the issue between them. Because of these inner battles, most participants seemed to prefer the idea of individual therapy. Particularly, participants acknowledged the importance of allowing space during therapy to understand personal backgrounds, for which individual therapy was unanimously declared as most conducive. Therapy was found to provide the need to feel safe in a secret environment, to make disclosures without the fear of retribution. This consolidates previous findings which show that SA males are reluctant to attend health services and that problem gamblers feel shame and stigma, which prevents them from seeking help. This provides new evidence that the combination of these characteristics may lead SA males to feel a heightened level of shame than their white counterparts.

The analysis suggests that CBT does not holistically alleviate the difficulties experienced by a male SA problem gambler. New findings highlight the fact that cultural issues were not addressed in the participants' CBT therapy, but that it can play an important part in how clients experience and negotiate PG, and therefore needs to be considered as part of their broader contextual experience. Current CBT may be neglecting cultural contexts and prevent SA male problem gamblers from addressing potentially secondary acculturation issues which could go some way in relieving

stress which may have an influence on taking up PG. This study highlights the importance of addressing unique dilemmas faced by male SA problem gamblers.

Another poignant discovery was the desire to be treated as British and an inner struggle to feel British, which contrasted with many of their upbringings and first-generation parents' values. Participants mainly found CBT to be acceptable for PG, however did not expect their cultural dilemmas (or other psychological issues) to be approached in this setting. There appeared to be a wish to regard culture with the same importance as other factors, and a hesitance to accept a difference between them and other British people. Therapists need to sensitively explore the need for this during expectation seeking in initial therapy sessions. Findings showed that people were not able to discuss individual issues openly in a group setting and there was an acknowledgement of shame, pressure and judgement from others. It could be assumed that this contradiction between the need to talk about culture and other factors, but wanting to feel as British as others, highlights a struggle between two conflicted components of a second-generation SA male and future work needs to look at the impact of negotiating identity with respect to culture in male SA problem gamblers. This study provides a preliminary step towards a deeper level of understanding of disproportionate gambling harms experienced and enabled by a combination of culture-gambling factors in SA men.

4.5. Reflexivity

My main struggle was that I found myself making comparisons between group and individual experiences, as this came up many times during the interviews. Particularly, I believe that individual therapy aligns with CP philosophy and its attempt to understand the individual in their context which CBT may sometimes disregard, especially in a group setting. I had to be mindful and refocus from this tension between CP philosophy and phenomenology, and the underlying assumptions of CBT for gambling, which views gambling as maladaptive behaviours resulting from distorted thinking. During the analysis, I came across a personal conflict due to a need for person-centred, explorative work to understand their identity and values, as perceived by myself as well as a craving often pointed out by the participant. However, it has been important to note that participants found CBT specific techniques useful (see section 3.i) as well as more generic aspects of the therapeutic relationship (see section 1.ii).

Participants seemed to be looking to me for validation or acknowledgement of certain aspects of culture, possibly due to my similar ethnic background. It was difficult not to respond to these small connecting phrases, such as "do we?" therefore, cultivating a deliberate stance of naivety was difficult, as I was also concerned that they felt judged by me, another member of their disapproving community. This may have adversely impacted disclosure and comfortability. They may have been looking for approval and understanding, which may have left them feeling comfortable disclosing, as I am conducting this piece of research, because I *know* what it is like. This illustrates that

even cross culturally, we can make assumptions about each other, and these can go unchallenged until confronted by findings or reflexivity. This also provides arguments for and against same ethnicity researchers and therapists and can form the foundations for new research.

I also felt an overwhelming sense of participants hiding things from their family, friends and others, which made me feel empathy towards them. I wondered if the purpose of being interviewed for some participants was that they had expected to feel therapeutically better, or even to find answers as to how they are able to address cultural issues. However, when the time came, it may have seemed too difficult to expose their vulnerability. I had expected to find this and may have pressed them with questions designed to reveal these feelings of needing to hide. I observed contradictions during questions of addressing culture from some participants and therefore it was difficult to take responses at face value. Some participants seemed to be creating 'live' hypotheses about their own cultural experiences. I also felt a responsibility to hold these discoveries sensitively. This really shocked me as a counselling psychology trainee, as we seek to understand the whole individual, which is also something that the participants were openly admitting to craving. I felt as though I was leaving some people in the lurch, by opening up a part of them and then leaving. This is when a debriefing conversation post-interview was invaluable for both of our potential anxieties. In line with this, during the process of analysis, I noticed that I was driven by a need to find similarities between participants, and noticed I was eager to group together and discuss these, especially when issues felt relevant to my cultural experiences. It was important to check in and maintain focus on the questions without making assumptions reflecting and confirming my own experiences, rather than my participants'.

I had some difficulty in rigorous selections and prioritising importance on behalf of the expert participant which meant I initially held onto themes before discarding them due to a worry of losing the identity and narrative of individuals (Smith & Eatough, 2007). Supervision was important in the process of generating ideas and interpreting emerging themes. Keeping a check on the integrity of interpretations within the data was done by reviewing the reflexive journal and notes made in order to let the individual's genuine views to come through. The process has been frustrating and rewarding at the same time. Practice and time made my analysis increasingly efficient, which continued until the very end. I have developed a patience required for creating robust, applicable experiential data, and increased my confidence in undertaking qualitative research, in particular IPA. This invaluable experience has compelled me to undertake further research to expand on this study.

4.6. Limitations

The study aim was to provide an in-depth exploration of second-generation SA males' experience of CBT for PG, for which the methodology corresponded. The aim of IPA is to make sense of individuals' experiences in order to contribute to a developing knowledge base (Smith et al., 2009), without the intention of making sweeping statements in relation to all SA problem gamblers. Therefore, these results should be considered within the context of the seven SA men interviewed for this research and be generalised to similar populations with caution. Though the small sample size may be criticised by some, this ensured the level of depth required to make sense of each individual's experience and is within doctorate IPA recommendations (Smith & Osborn, 2004).

The homogenous sample of second-generation, male SAs who had undergone CBT in the past year provided advantages when examining meaning across the sample. The inclusion of different treatment modes or religion may have impacted the homogeneity of the sample. However, this divergence also offered significant meaning to the research in terms of perceptions of therapy mode which can be built upon in future research. Additionally, a tendency within previous research to group SA cultures together may fail to appreciate distinctive features of each ethnic group. The variance between three ethnicities could have been viewed as perpetuating the same issue and adds a further limitation to homogeneity. However, a form of verification through similar experiences across the ethnicities was deemed to have been offered in the findings.

Though this study attempted to provide transparency at all stages of the process, it should be known that the interpretative process and resulting themes have been derived according to the researcher's perspective, and others may have found different pertinent themes. In IPA, this double hermeneutic process of meaning making is integral in its focus on the researcher making sense of the participants' experiences. Though the researcher was mindful of engaging in leading questions, there will inevitably have been an affect on interpreted themes. To allow participants to express further relevant thoughts, they were invited to provide further comments at the end of the interview.

Participants revealed a difficulty in talking openly about personal matters, and subsequently may have felt exposed and judged during the interview process. It may have been helpful to explore options in order to build rapport with participants, such as another interview, to allow participants to feel more at ease. There is an argument for having a SA therapist whom the client may feel more comfortable with and assume will have a level of knowledge to understand their cultural histories and pressures. There may be an underlying fear that these experiences may stoke underlying prejudices about the culture from people outside of the community. A potential area of enquiry would be to understand if therapist ethnicity has any bearing on experiences for this client group.

4.7. Recommendations

Many recommendations follow on from those provided by participants. SAs finding it difficult to come forward and seek help, made easier by the fact it can remain relatively hidden has clinical implications, and potentially damaging effects on an individual should they not enter therapy. This may further marginalise and perpetuate the difficulties and isolation they experience. It is important that true numbers of SAs suffering from gambling addiction should be ascertained and targeted for intervention. In order to do this, access, awareness and acknowledgement of the importance of individual therapy seems paramount. For SA males, individual therapy may be more acceptable and provide a safe space to understand their stigma and shame for a population who may otherwise find it difficult to expose their vulnerabilities.

A conflict between cultural identities may lead to SAs not wanting to admit there is a difference and attend to it, as no-one would potentially understand them. It would be a scary prospect, especially if hearing about other members of the community becoming ostracised or misunderstood. It was interesting to note that participants' parents were ethnically matched which made me wonder if a cultural dissonance may be more pronounced in children with parents from similar backgrounds. Those that marry culturally similar partners could mean that culture plays a large role in their lives. Cultural pressures may then be delivered by both parents as well as actively encouraging a culture driven household, including engaging in traditions.

It is possible that they are more embedded in their native culture and more apprehensive about branching out in the new environment in which they live, coined separation acculturation (Berry, 1990). This parental makeup lends itself to deeper culturally related inhibitions (conscious or not) with regards to exposing difficulties and a tendency to hide problems. It is something to be considered for future study as hiding the problem behaviour may inadvertently lead to more gambling harms (Kolandai-Matchett et al., 2017). Given the potentially large role played by the family and parents in SA men's gambling, family therapy may be something to consider in this population.

CBT therapy does not readily lend itself to understand the idiosyncratic nature of an individual in their world, which CP seeks to establish. Perhaps the therapeutic qualities of the alliance, which has often been deemed as the best predictor of treatment outcome (Safran, Muran & Proskurov, 2009) can be incorporated into manualised therapies alongside tackling the cognitive and behavioural difficulties of gambling specific aspects. Participants allude to the helpfulness of both types of therapy and highlight their differing objectives. After group sessions, follow up interviews can assess clients' ongoing needs in an attempt to address other relevant aspects and individual triggers, such as culture. There is a risk that if culture is not touched upon, clients may not think to mention or believe that it is relevant. SA males may also be considered as priority for individual therapy and attend simultaneous group therapy to consolidate CBT techniques in order to provide more space in individual therapy to explore family backgrounds if deemed important. More research is needed to help understand the types of therapy format, approach

or needs that might support this population better. This research suggests that adaptation of CBT to culture may be valued by clients as has been previously found in SA populations with depression and psychosis (Naeem et al., 2015; Naeem et al., 2014; Rathod et al., 2013).

Greater awareness in SA communities could go some way to dissipate stigmas surrounding gambling and seeking help. Recognising the signs can go some way to counteract its "hidden nature" (Bond et al., 2016, p. 3). This includes providing materials to highlight the status of PG as an impulse disorder with impaired control, which may tackle stigmatising beliefs from both the self and the community (Hing et al., 2016). This may make members of the community aware of the importance of therapy and support, and offer advice on how to detect these issues. Addressing clients' shame and perceptions of stigma during therapy may be important (Dunn et al., 2012) by shifts in concepts of self-identity and reshaping of the self, which have been found to be integral to the process of recovery from PG (Reith & Dobbie, 2012). Prior to this, counsellors reported that empowerment, self-esteem and trust need to be rebuilt before changes in gambling can occur (Dunn et al., 2012; Hing et al., 2016), which may be harder for those already apprehensive in a group setting. Accepting, non-judgemental and non-stigmatising attitudes can help to overcome deep shame during therapy (Anderson, 2014).

5. References

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6. Appendices

A.1 National Health Service Ethical Approval

South West - Frenchay Research Ethics Committee

Level 3, Block B
Whitefriars
Lewins Mead,
Bristol BS1 2NT
Email: nrescommittee.southwest-frenchay@nhs.net

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

19 September 2016

Miss Sheetal Dandgey
Counselling Psychologist in
Training London Metropolitan
University
166-220 Holloway Road
London
N7 8DB

Dear Miss Dandgey

Study title:	**Experiences of CBT therapy in South Asian men with problem gambling: An Interpretative Phenomenological Analysis**
REC reference:	**16/SW/0141**
Protocol number:	**N/A**
IRAS project ID:	**198080**

Thank you for your letter of 12 September 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Miss Natasha Bridgeman, nrescommittee.southwest-frenchay@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites
The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Contract/Study Agreement [University Ethical approval]	1	07 March 2016
Covering letter on headed paper [Covering letter]	1	04 July 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University Indemnity]	1	05 April 2016
Interview schedules or topic guides for participants [Interview Schedule]	1	02 March 2016
IRAS Application Form [IRAS_Form_27042016]		27 April 2016
IRAS Checklist XML [Checklist_27042016]		27 April 2016
Letters of invitation to participant [Opt-in Form]	1	02 March 2016
Other [Distress Protocol]	1	02 March 2016
Other [Demographic Data Sheet]	1	02 March 2016
Other [GCP Sheetal Dandgey]	1	16 November 2015
Other [Inclusion/Exclusion Criteria]	1	02 March 2016
Other [Debriefing Document]	2	16 June 2016
Participant consent form [Consent Form]	1	02 March 2016
Participant consent form [Consent Form]	2	16 June 2016
Participant information sheet (PIS) [Participant Information Sheet]	2	16 June 2016
Research protocol or project proposal [Research Proposal]	3	04 July 2016
Summary CV for Chief Investigator (CI) [CV Chief Investigator]	1	19 February 2016
Summary CV for supervisor (student research) [CV Angela Louolopoulou]	1	16 March 2016
Validated questionnaire [Risk Screening Measures]	2	16 June 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

16/SW/0141	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Mr Stephen Draper Chair

Email:nrescommittee.southwest-frenchay@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr Angela Ioanna Loulopoulou*
Mr Pushspen Joshi, NoCLoR

A.2 University Ethical Approval

London Metropolitan University School of Psychology Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology Mr Robin Iwanek and the Dean of the FLSC, Prof Dr Dominic Palmer-Brown to proceed with the following research study (professional doctorate):

Title: Experiences of CBT therapy in South Asian men with problem gambling: An Interpretative Phenomenological Analysis

Student: **Ms Sheetal Dandgey**

Supervisor: Dr Angela I. Loulopoulou

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 7 March 2016

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

A.3 Screening Form

Research Project: Experiences of CBT therapy for gambling in South Asian men

GAD-7 & PHQ-9 screening questionnaires

NAME:……DATE: .....

Over the last ***2 weeks*** how often have you been bothered by any of the following problems ?

PHQ-9	***SCORE :***	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure, or have let yourself of your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Exclusion

GAD-7	***SCORE :***	***Not at all***	***Several days***	***More than half the days***	***Nearly every day***
1.	Feeling nervous, anxious or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

Table of score interpretation (not to be sent out to participants)

PHQ-9 Depression Severity	***GAD-7 Anxiety Severity***
0-5 mild	0-5 mild
6-10 moderate	6-10 moderate
11-15 moderately severe	11-15 moderately severe anxiety
16-20 severe depression	15-21 severe anxiety

Cut off points

A.4 Information Sheet

Participant information sheet

Research Project: Experiences of CBT therapy for gambling in South Asian men

Dear Volunteer,

Thank you for showing interest in this research project.

I am a trainee counselling psychologist at London Metropolitan University. As part of my training, I will be conducting a research project to discover more about South Asian men's experiences of therapy for their gambling. For this study I am looking for people who:

- **Have had cognitive behavioural therapy for their gambling in the last year**
- **Are of South Asian British ethnic background**
- **Identify themselves as being second generation South Asian**
- **Speak English fluently**
- **Are 18 – 65 years**
- **Are male**

Very little is known about the experience of South Asian men and gambling. Limited research has been conducted in this area, meaning that services may not be implementing culturally sensitive interventions which may be important for South Asian individuals seeking help. My hope is that by carrying out this research we will be able to gain a better understanding of South Asian men's experiences of gambling and experiences of seeking help and therapy. I hope to elicit an understanding so that those who are struggling with gambling are able to get the support, help and services appropriate for their needs.

I am writing in the hope that you will be interested in helping me in this endeavour and share your experiences of therapy for gambling by participating in an in-depth interview. As you have previously been involved in this service and have identified gambling as being a problem in the past, I would like to hear about your experience of cognitive behavioural therapy (CBT). The interview would last for approximately 1 hour and will be voice recorded to allow your responses to be reviewed in detail by me after the interview. Interviews will be strictly confidential (but please note that confidentiality might not apply

in certain circumstances, e.g., if information is disclosed that indicates a risk to yours or someone else's safety).

If you do decide to take part, a short questionnaire will be conducted over the phone to assess your suitability to take part, by asking how things are for you at the moment. A time convenient for you will then be arranged to meet. If you decide to take part, you will be asked to sign a consent form. Participation is entirely voluntary. If you choose to participate you are free to withdraw at any point (up until **27.07.2016**) without giving a reason, and your data will be destroyed.

All recordings will be kept securely. Your name or any identifying information will be removed from the data, and will not be quoted in the study report. The consent forms will be kept separately from the data, and will only serve to verify that proper consent has been obtained. Please note that my director of studies or the external examiner may request access to the raw data for verification purposes. This data will not contain any names. Data from your interview will be used for my Doctoral level counselling psychology project. During analysis, I may want to check that you are happy with the meaning I have gathered from the interpretation of your questions, and will therefore contact you to validate this.

I would also like you to know that I am intending to submit the completed study for publication in an academic journal. If quotations are used from your transcript, I will check that you are comfortable with these. This will also not contain any names. Successful publication would require me to retain all data for a certain length of time. This could be around five years, depending on the journal, after which it will be destroyed. All interviewees are invited to request a copy of the final study after publication. This will be available in 2018/19.

Before you decide to participate it is more important that you understand that the interview may be an emotive topic for you and therefore may evoke some difficult feelings in you. Please take your time in deciding whether or not you wish to take part. You will have the opportunity to discuss any issues that come up as a result of the interview with the researcher and be given information on further sources of support if you would like this.

This study has been approved by the London Metropolitan University and Central and North West London Research Ethics Committees and will be conducted in accordance with the ethical guidelines provided by the British Psychological Society. If you have any questions,

comments or complaints about this study please get in touch with me on the details below. Alternatively, you can contact my director of studies, **Dr Angela Loulopoulou** on **020 7133 2667** or email at **a.loulopoulou@londonmet.ac.uk**.

Thank you so much for taking your time out to read this, if you have any further queries or are interested in taking part, please do not hesitate in contacting me either by phone: **07590250476** or email: **sheetal.dandgey@nhs.net.**

I will call you a week after I send out this information sheet to see if you would be interested in taking part.

I look forward to speaking to you soon.

Yours Sincerely,

Sheetal Dandgey
Counselling Psychologist in training

A.5 Consent Form

Consent Form

Topic of Study: Experiences of CBT therapy for gambling in South Asian men

Researcher: Sheetal Dandgey

Read each of the following points carefully and ask the researcher any questions if unsure.

1. I confirm that I have read and fully understood the information sheet for the above named study and have had the opportunity to ask questions.

Please initial box.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. However, all data will be collected by December 2016; therefore, if I wish to withdraw it has to be done by 27.07.2016.

Please initial box.

3. I understand that participation in this study is anonymous. My name will not be used in connection with the results in any way, a pseudonym will be used on the digital voice recording and all information that may otherwise identify me (e.g. address, names) will be changed prior to transcription. There are limits to confidentiality however; confidentiality will be breached if I disclose any information that the researcher perceives to be a risk to the safety of myself or others, and the appropriate authorities contacted.

Please initial box.

4. I understand that the results of the study will be accessible to others when completed and that excerpts from my interview (minus explicit identifying information) may be used within the study.

Please initial box. ☐

5. I understand that, if during the interview I disclose any illegal activity such as murder, organised crime, sexual abuse, physical abuse, terrorism, money laundering, this would have to be disclosed to the appropriate authorities and confidentiality would be breached.

Please initial box. ☐

6. I would like to be sent a copy of the findings once the data has been analysed (OPTIONAL).

Please initial box. ☐

7. I understand that the data will be destroyed once the study has been assessed. However, if the data is published in a journal, I understand that it will be kept for an amount of time specific to the journal, usually 5 years.

Please initial box. ☐

8. I understand that the researcher will provide me with one copy of this form, keep one at the site where I was recruited and put one in my medical records.

Please initial box. ☐

9. I understand that the researcher may want to contact me to check that they have fully grasped the meaning of my answers by sending me a copy of the analysis to look over (OPTIONAL).

Please initial box. ☐

10. I agree to take part in the above study.

Please initial box. ☐

Signature of participant:……..... Signature of researcher:…….....

Print name: ……..... Print name:…….....

Date: ……..... Date: …….....

A.6 Demographics Form

Demographics form

Participant ID: .....

Age: .....

Gender: .....……

Religion: .....……

Place of birth: .....……

Nationality: .....……

What ethnicity would you describe yourself as?.....

Mum's ethnicity: .....

Dad's ethnicity: .....

Length of Therapy: .....……

Dates between which therapy was completed ..... ……

A.7 Interview Schedule

Interview Schedule

1. Experience of CBT therapy

First of all, would you like to tell me a little bit about your experience of this particular therapy?

Prompts:

How did you feel about CBT? Do any thoughts or feelings come to mind when you think about the therapy that you experienced?

What was it like for you to be undertaking CBT? What was it like for you to discuss any problems or difficulties you were experiencing?

Can you tell me what therapy means to you?

***2*. Experience of therapy before**

What were your thoughts and feelings about therapy before you sought help for gambling?

What were your perceptions about the benefits or changes that may come about in therapy?

Prompts:

What did you hope to learn from therapy?

Was there any apprehension before starting therapy?

Did you have any other experiences of therapy before this?

3. Experience of therapy during

Was there anything in particular you found *helpful* in therapy?

Was there anything in particular you found *unhelpful* in therapy?

What was your experience of the therapist?

Prompts:

Did you find anything in particular during your sessions, which was useful/ not useful in working through your gambling problem?

Did you feel understood by the therapist? Is there anything you would have changed about your therapist or the way they dealt with certain things?

4. Experience of therapy after

How has the process of therapy helped you?

Were there any ways in which therapy did not meet your expectations?

Did therapy exceed your expectations in any way?

Would you recommend CBT to a friend? Would you give them any advice if they were going to access the same therapy?

Prompts:

Did CBT bring about any change in your gambling behaviour?

Could therapy have been better for you in any way? What could it have done that it didn't do?

5. Cultural Background

How important is your cultural identity to you?

What role does your culture play in your life? Does it have any influence on any aspects of your life?

6. Culture and CBT

Did you talk about culture during your therapy? If so, what was that like? If not, do you think it may have been helpful to talk about it?

Do you think that therapy was suitable with regards to your cultural background?

Did you find any conflict between your culture and therapy? Is there anything you feel that therapists should consider prior to providing therapy for South Asian males within your community?

Is there anything that might stop South Asians from having therapy? If so, are there ways to improve this/provide access?

7. Ending Questions:

If you knew before what you know now about therapy, would you have done things differently?

If you could change things about the therapy you received, how would you suggest CBT could be tailored to your needs?

Is there anything else you would like to add or talk about that you think might be relevant to our discussion about your experience of therapy?

What has doing this interview been like for you? Is there anything you would like to ask me about our discussion?

A.8 Debriefing Form

Debriefing Document

Research Project: Experiences of CBT therapy for gambling in South Asian men

Dear Participant,

Thank you very much for taking part in this study, which is part of a Doctoral project that the researcher is conducting. Your time and effort is greatly appreciated. If you have any questions or concerns following the completion of the study, or would like to withdraw, please contact:

Sheetal Dandgey
sheetal.dandgey@nhs.net
07590250476

Please remember that if you wish to withdraw from this study, it should be done by **27.07.2016** as it may not be possible to at a later stage.

If you have any complaints regarding any aspect of the way you have been treated during the course of the study please contact my director of studies Dr Angela Loulopoulou on: **020 7133 2667** or Email: a.loulopoulou@londonmet.ac.uk

If participation in this research has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support in confidence:

- **GamCare.** The GamCare Helpline provides confidential advice, information and emotional support throughout Great Britain to anyone experiencing problems with gambling. Website: http://www.gamcare.org.uk/ or phone them on **0808 8020 133**

- **Gamblers Anonymous** is a fellowship of men and women who share their experience, strength and hope with each other, with a view that they may solve their common problem and help others to do the same.
  Website: http://www.gamblersanonymous.org.uk/ to find a meeting near you.

- **MIND** is an independent charity which offers the following services: supported housing, crisis helplines, drop-in centres, employment and training schemes, counselling and befriending. Find your local MIND service here: http://www.mind.org.uk/information-support/local-minds/.

- **IAPT** is a primary care psychological service for individuals who experience common problems including anxiety and low mood. The support offered is Cognitive Behavioural Therapy. Information and contact details for local services across the country can be accessed in the Therapy and Counselling services directory on the NHS Choices website at http://www.nhs.uk.

If you have requested a copy of the findings, then this should be available and sent out to you in 2018/19.

Thanks again,
Sheetal Dandgey

A.9 Distress Protocol

Protocol to follow if participants become distressed during participation:

This protocol has been has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the present research study on South Asian men's experiences of problem gambling. Such participants may have experienced distressing situations when they experienced problem gambling, and in some cases, these problems may be current. Sheetal Dandgey is a trainee counselling psychologist at London Metropolitan University and has experience in managing situations where distress occurs.

Below details a three step protocol describing signs of distress that the researcher will look out for, as well as actions to take at each stage. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. This is because most of the participants will have been accessed professional services within which there will usually be an existing structure set up to deal with extreme distress which professionals can implement. However it is included in the protocol, in case of emergencies where such professionals cannot be reached in time.

Mild distress:

Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

1) Uncontrolled crying/ wailing, inability to talk coherently
2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3) Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

1) The researcher will intervene to terminate the interview/experiment.
2) The debrief will begin immediately
3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal and distressing events.
5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6) Details of counselling/therapeutic services available will be offered to participants.

Extreme distress:

Signs to look out for:

1) Severe agitation and possible verbal or physical aggression
2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

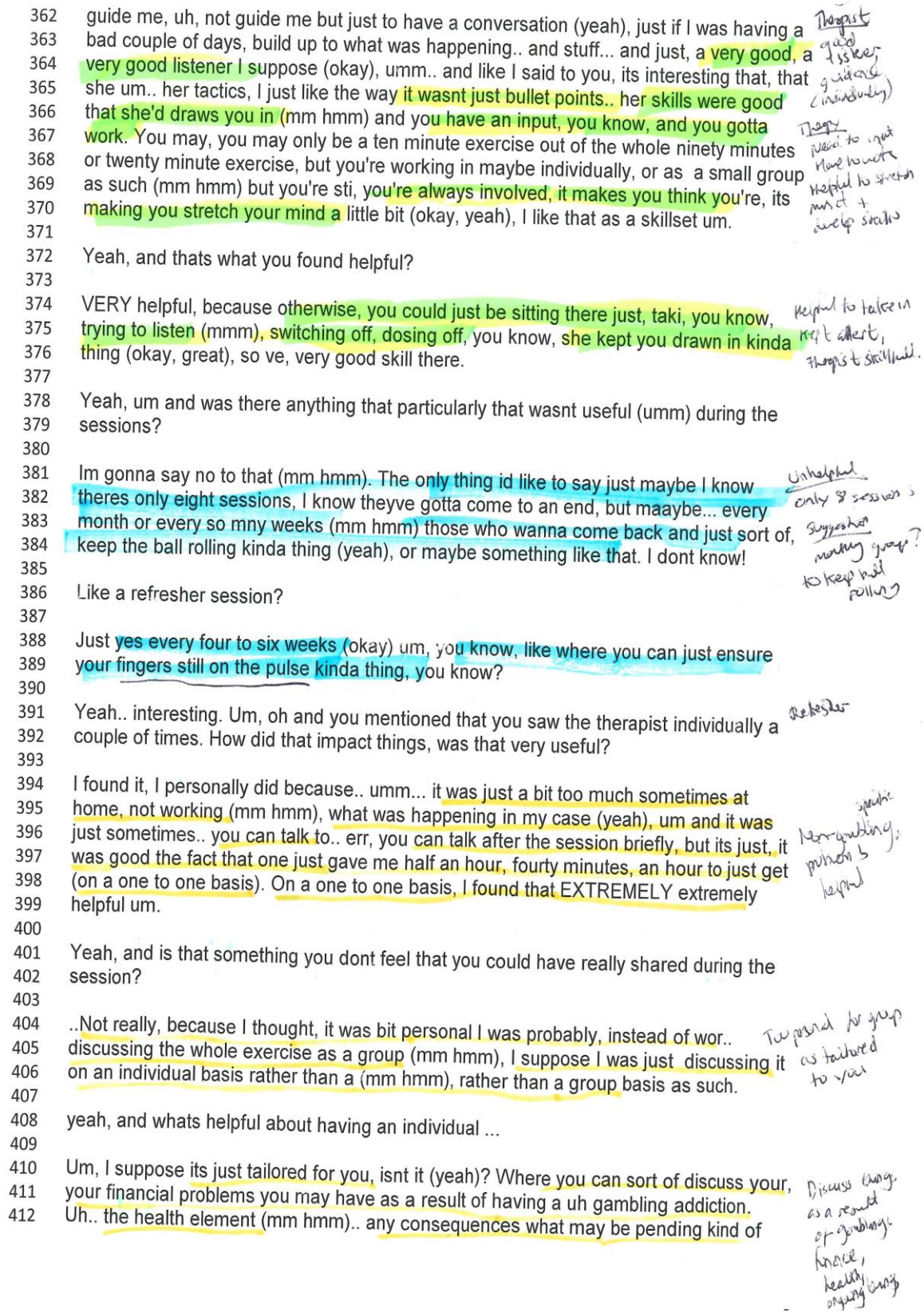
Action to take:

1) Maintain safety of participant and researcher
2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.

If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

A.10 Transcript Excerpts

A. Transcript Excerpt Sandeep including preliminary superordinate themes and subthemes



guide me, uh, not guide me but just to have a conversation (yeah), just if I was having a bad couple of days, build up to what was happening.. and stuff... and just, a very good, a very good listener I suppose (okay), umm.. and like I said to you, its interesting that, that she um.. her tactics, I just like the way it wasnt just bullet points.. her skills were good that she'd draws you in (mm hmm) and you have an input, you know, and you gotta work. You may, you may only be a ten minute exercise out of the whole ninety minutes or twenty minute exercise, but you're working in maybe individually, or as a small group as such (mm hmm) but you're sti, you're always involved, it makes you think you're, its making you stretch your mind a little bit (okay, yeah), I like that as a skillset um.

Yeah, and thats what you found helpful?

VERY helpful, because otherwise, you could just be sitting there just, taki, you know, trying to listen (mmm), switching off, dosing off, you know, she kept you drawn in kinda thing (okay, great), so ve, very good skill there.

Yeah, um and was there anything that particularly that wasnt useful (umm) during the sessions?

Im gonna say no to that (mm hmm). The only thing id like to say just maybe I know theres only eight sessions, I know theyve gotta come to an end, but maaybe... every month or every so mny weeks (mm hmm) those who wanna come back and just sort of, keep the ball rolling kinda thing (yeah), or maybe something like that. I dont know!

Like a refresher session?

Just yes every four to six weeks (okay) um, you know, like where you can just ensure your fingers still on the pulse kinda thing, you know?

Yeah.. interesting. Um, oh and you mentioned that you saw the therapist individually a couple of times. How did that impact things, was that very useful?

I found it, I personally did because.. umm... it was just a bit too much sometimes at home, not working (mm hmm), what was happening in my case (yeah), um and it was just sometimes.. you can talk to.. err, you can talk after the session briefly, but its just, it was good the fact that one just gave me half an hour, fourty minutes, an hour to just get (on a one to one basis). On a one to one basis, I found that EXTREMELY extremely helpful um.

Yeah, and is that something you dont feel that you could have really shared during the session?

..Not really, because I thought, it was bit personal I was probably, instead of wor.. discussing the whole exercise as a group (mm hmm), I suppose I was just discussing it on an individual basis rather than a (mm hmm), rather than a group basis as such.

yeah, and whats helpful about having an individual ...

Um, I suppose its just tailored for you, isnt it (yeah)? Where you can sort of discuss your, your financial problems you may have as a result of having a uh gambling addiction. Uh.. the health element (mm hmm).. any consequences what may be pending kind of

thing, and not only that, but you know, not on.. so..as much as its about you, the impact its having with the people around you (mmm), the family element of it, you know.

Yeah, so it sounds very tailored to you.

Yeah,you know, um, but you know, yeah. and one, one, one thing I just wanna touch on is its quite interesting i, iv, got a couple of older brothers..(mm hmm) and I was saying to my wife only how difficult it is for some people to accept what you've done and the type of help you can have um..

Right, tell me more about that.

I asked, me and my b, I went out and had a drink with my brother a week, uh several weeks ago and he said to me 'how you getting on' and whatever and he, he used the terminology, you know, I need, I got lots of qu, i need lots of answers from you. Why youve done this, the impact its had on the family.. and, and I said to him.. id like you to come to one of, the group session so maybe you can have an understanding about it (mm hmm).. and instead of looking at it from me, that you have a concept of the gambling element as a whole kinda thing, and his answer was 'I don't need to do that. I've watched a programme and i've, and I understand it.' And I asked him, I said, 'what did you understand out of a .. out of a programme for half an hour, fourty minutes, an hour?' (Mmm hmm), I said 'What do you understsand from a gambler's perspective in an hour?' And.. not really, I didnt get the answe, so what im trying to say is... you know, his.. his conception was, you know, what it is i've done, he only wanted to take in what i've, from a negative point of view what I have done, what the impact its had (okay), the, probably the embarrassing side.

In what way?

In, but to the family I suppose, its broken a family up (yeah). Um...so, you know, to him, its probably more so.. broke the family up, family names not very good (mm), we're all successful, whats happened to you? (Okay). You know (yeah), so um.. but i'm just gonna put that on to one side, you know, its, its, you can tr, I can only try ad educating him a little bit, you know.

yeah, since you've touched on family, how has it impacted..

MASSIVELY (your family), MASSIVELY. Um, how do I say. It hurts me to say that my wi, we, we've separated or we're gonna get a divorce so firstly (okay), which is (sorry to hear that) frightening. SO, you know, I find that, I found that kind of... very difficult to come to terms with. Thats number one umm.. Ive got a younger brother, two older brothers and a sister (mm hmm). Um, my eldest brother, like i.. is the person i've described you and I find him very difficult to understand um, what i've done but its, you know. My other brother, his wife.. um.. directed me to the help groups available (okay). Uh, my sister was very angry with me intitially. Shes come to.. shes accepted the help im getting (mm hmm) and shes ver, shes been to a g, been to quite a few sessions herself to under, to have an understanding behond it (right). Umm.. and shes quite please up to the leve of support ive had up to now and what ive done.. the direction i've moved toewards, so um.. shes quite, shes very, shes been EXTREMELY supportive (mm). Uh, my younger brother.. um.. he sort of keeps himself to himself, he doesnt really discuss it, in terms of what am I doing, he doesn't ask too many questions about it so (sure), theres a little bit of distance um, but theyve all got their own businesss, so theyre probably

kinda wrapped up in their wo (okay), you know world kinda thing. Um, its interesting, I do wanna tel my Mum about this, but my father passed away firstly when I was a young boy, so (mmm), and, so um, my mothers brought five of us all up,um, she knows what i've done, she knows the implications it had up to er, a couple of weeks ago um... shes quite, like shes very devastated in terms of the impact its had um, on the family um.. and her exact words were 'I didn't think you'd, you know, you'd do this, why did you?' She had, she had relevant questions and um.. concerning questions and, you know, I spoke to her yesterday and she said just ensure that you keep away from these negative thoughts and dont, you know (okay), so. But, the, you know, as a whole the the family scenario, its er, ive lost their trust (mmm). Umm, its hard, I cant, I, because i've lost their trut, I find it difficult to um, and, ive lost their trust, theres a little bit of un.. er.. I feel uncomfortable about it, myself because of what i've done, because its negative (mm hmm).. the vibe I get, I kind of distance myself from them slightly, um., I dont wanna particularly see them (mmm), bec.. just the fact that, you know, I dont want any negative thioughts and therefore I dont wanna, because its negative, I dont want it to even trigger anything off, you see (okay). I dont wanna get frustrated or angryor pissed off the fact that'oh they pissed me off, i've, i've got twenty pound, im gonna, as they've pissed me off (right), im gonna go and have a bet.' I don't wanna, do you know what I mean, because its negative, keep away from the negative. You know, so, um not as, you know, so i'm just.. I keep it to a minimum (yeah), where possible.

From 42:04

And, how important is your cultural identity to you?

... probably more so now than ever before! (yeah) Right or wrong reasons I dont know, I kind of.. you kno, because I turn round and look at it, its gonna be a wrong ans, im gonna give you the wrong answer now, I feel.

No, there are no wrong or right answers, its just..

Well, I.. I.. think so because, you know, we're separating (mm). In the Asian, in the, in the Asian.. cultural.. belief or whatever the correct terminology is, that you know, we, through thick and thin, we stick to it.. but.. now i've found, maybe because im on the receiving end of it all, and i, ive, i think to myself.. I kinda said to my wife.., you know.. 'listen, we've gone through a bad patch and, yeah, it is what it is, look lets try and..' But she's good, you know, she's as stubborn as she may be, she's thinking about herself and our, and our child, our son, so, you know, if this is, if this is what it is, it is what it is, so um.. I dunno, I kinda use the cultural thing, you know we should, sort of... its not right or wrong, but.. I dunno, it doesn't really mean anything, (No) I suppose.

No. And so throughout your life, for example, and before this has happened, how, how important was it to you? Were you part of a, a community of, you know Indians or Sikhs.

Um, yes, but I didn't, I wasn't, sorry (its okay), umm.. umm, I didn't, I wouldn't really socialise too much (mm hmm). Um, I'd go to the, you know, i'd go to the temple either when im needed um.. you know, probably twice a year, something very little. Um... but now, I dunno why, when its negative.. not negative, but wh, I suppose when you need help you ki, you have that little bit of belief thinking 'maybe I should believe in my, culture and if I believe in my culture.. good things may happen.' That thought has gone through my mind a little bit (yeah), you know.

004

CBT

Context
- A1 12 sessions one-to-one
- A1 open forum
- A1 useful
- A1 covered family problems + gambling-offending

Helpful
- F Relaxing
- F Interesting listening to others
- F About input of others
- F People with similar problems
- F Cherry pick what works for you.
- F Escapism / not tense
- F Shocked
- F Differences were fascinating – removing self from other gamblers?
- X People had different personal issues
- F Stretch mind + develop skills
- M2 Triggers, impact + prevention
- F Feel supported
- F Going to 2nd group (more taken in) ie 4/10 → 8/9 /10
- ✗ Not gambled – to gamble would help disregard issue

Suggestions
To others
- E2 Have to want therapy – A2 wasn't sure at first + later accepted
- E2 Need to accept wrong + need help
- E2 First thing he's done
- E2 Therapy helps if you accept
- E2 Need to put in effort

To team
- A1 Not recognised enough – support option
- X Gambling industry strong marketing – addiction to blame?
  - more ownership, government help, more support
- X Frightening reality of addicted inds at betting shops
- X a realisation of the immense world of gambling
- A1 Monthly groups? To keep ball rolling / refresher – extend therapy

Barriers
- L Stigma
- L Accepting problem

Pre-therapy
First Impressions
- A2 Daunting
- A2 Unknown first time
- X Eased soon after
- A2 Who's going to be there
- F Uncomfortable at first
- F Surprised / frightened by youth
- A2 Against therapy initially
- A2 No expectations
- A2 Hoped for a cure → help

During
- F Comfortable discussing difficulties

Therapist
- H Understanding
- H Helpful
- H Sought individually to get guidance
- H Good listener
- H Skilful
- H Kept group alert

Individual
- G Non-gambling patterns
- G Extremely helpful
- G Too personal for group as tailored to you
- G Things discussed as a result of gambling ie finance, health, on party issues
- G Impact on you and ppl / family around you
- G Individual ideal
- G What made you do it, impact, implications
- G Specific problem solving + moving on.

N) Nature of gambling
- Enjoyed lifestyle
- Greed
- Good job → loss → criminal record
- Stole a lot of money
- Broke law → avoided jail
- Divorce – difficult to come to terms with
- Drawn into addiction, ignore everything else
- Wants to be an advocate for youth – empathy?
- A2 Sought help when lost job ie big consequence → frightened + scared

Techniques
- M1 Triggers ie spare time
- M2 Structuring day / routine ie gym
- M2 Restricting money on person
- M2 Distracting self ie reading
- M Behavioural – use up energy / spare time, don't go

Not helpful – CBT
- M1 Barring self from shop – uncomfortable
- M1 X Alcohol has no impact
- M1 Can watch football without betting
- M1 Only 8 sessions
- M Cannot talk about personal issues
- F Patronising towards other group members?

Culture

Family
- Q Sister-in-law (Dr) referred
- Q Letting family down (wife + son)
- Q Difficult for others ie brother to accept – disappointed in brother?
  - ie not understanding – asking why
  - emphasises impact on family
  - rejected offer to visit group – Not willing to understand perspective as feels he already understands enough
  - broke family up, dared family name – cultural stigma, embarrassed? – Male perspective?
- M Success important to family – feels he has messed that up
- Q Sister angry initially → been to sessions → pleased + accepted getting help
- X Younger brother distant, siblings in own world – excusing them?
- Q Brother said 'the family' – disgust / disappointment, guilt affected extended family
- L Wouldn't go to community event – worried about ppl judging? Gossiping?
- L Praised event in family – Feels judged, unwanted, doesn't deserve happiness?
- L Asians don't like to accept form of therapy

Group + Individual

Mum
- L Stigma for anything ie drinking, drugs
- E2 Need to accept not push
- L Stigma generation – deal with problem today is different
- Q Devastated
- Q Disappointed
- Q Concerned
- Q Asked to keep away from negative thoughts – Mummy?
- Q Why did you do this?
- Q Lost trust, uncomfortable
- Q Distancing self as negative atmosphere → triggers / avoid frustration / anger) – Avoiding difficult situations / doesn't feel understood / support

Culture in therapy
- F Interesting to hear from others
- F Interesting to talk in therapy ∴ love open
- F Culture excludes group if not all SA
- G Important to raise in individual therapy due to individual impact
- X Sees lots of Asian men in betting shops – young + old – shocking
- X Shops drawing Asians in (easy money) who don't used to know about it

Meaning of Culture
- P More important now, didn't believe it before + did own thing.
- P Have to stick through thick + thin – tried to persuade her – patriarchal?
- P Not really socialise with community
- P When something negative, maybe he should believe in culture + good things may happen.
- P Culture + religion come hand in hand
- P Maybe it's positive
- P Today may embrace it more

B. Transcript Excerpt Aman including preliminary superordinate themes and subthemes

So, I don't know if you can expand more on why you thought you'd be more comfortable with a male?

I dunno, um.. maybe because i'm more comfortable with guys generally [mm hmm], umm.. maybe because it's the form of gambling I do, I thought that a male could relate to it more, so maybe understand it more [right, okay]. Umm, I just thought i'd be more comfortable just generally opening up.

Yeah, okay. Um.. and did you feel understood by the therapist?

Yeah.

Yeah. Is there anything you would have changed about her?

I don't think so. Again, she probably couldn't relate to the whole sports side as much as maybe some guy one coulda done, but the theory in generally, rugby, sports, other types of gambling is pretty similar [mm hmm]. So, she focused more on that and, I could relate that to the whole sort of what I was gambling on, to bring it together [yeah] um.. so I don't think I would have changed anything. Again, the other thing she was flexible about was like "look, she should really have sessions every two weeks." I know, if you look at it, we had eight sessions over what, four, five months. We took longer than we should have done, umm, cos I know there was a gap where I was like "look, i've got holidays coming up for two, three weeks [oh yeah], umm over Christmas. I'll have time on my hands, i'm probably a lot more concerned about something happening then." [mm hmm] Can we maybe not have sessions then, but sort of stagger it a bit longer, and have some sessions after Christmas and she was like "yeah, fine. No problem."

Okay, good! Um.. and.. how has the process of therapy helped you? You talked about some things you might now put in place [mm hmm] um, is there anything else?

Look, I know there's things I stil.. there's things I have done, there's things I still need to do. Umm.. so I still, i'd like to replace that therapist with someone else that I can.. that's something we did talk about, you know, having somebody that I could, go into a room like this and open up to [yeah] and talk about it quite openly. Umm, but it's quite difficult to identify that person 'cos you've got people that you're very close to [mm], you don't want to judge [mm hmm]. You've got people that can't really relate to you umm, so getting that right balance of person is quite difficult [yeah]. Umm, so that's the one thing which, I know we did discuss in the therapy sessions, which I did did away, which i've probably not implemented yet [no]. But in terms of the other controls, yeah xx.

Okay, okay. Um.. and were there any ways in which therapy didn't meet your expectations?

No really, look, the only thing i'd say is, therapy is a two way process. So you could give me all the advice, I could listen to all the advice, but it's down to me to take it away and err.. you know, have that will power and strength to, to stop gambling, or control gambling, whatever [yeah]. You can tell me everything you want in an hour, but it's down to me at the end of the day [mm hmm] ermm.. so.. in terms of the theory, in terms of the process, i've got nothing but positive to say about that. Umm, but again it's a two way process, so it's down to the individual as well [yeah] to wanna take that advice and, you know, do what he needs to do, be strong enough.

Yeah, okay. And would you recommend CBT to a friend?

Yeah.

256 Yeah, umm, and would you give them any advice if they were going to access the same type of therapy?

Umm... the only thing i'd say is what i've said before already, right. Um, go in with an open mind.. umm, try not to have too many preconceptions [mm] 'cos you'll probably get them cleaned up in the first session. Um.. and you've got nothing to lose.

Yeah. And maybe a bit about the, the responsibility, the two way thing. I guess that's something that you've taken away. Exactly.

Yeah, yeah. Um... okay, so know i'd like to talk about your cultural background. So just an open questions; can you tell me about your cultural background?

Look, i'm Hindu [yeah], umm.. i'm not that religious umm, I... my Mum is, my wife to some extent is [mm hmm] umm.. but in terms of my cultural background, i've been to India a lot of times, um, especially when I was younger, but it's not something i'm, you know, totally, totally into [mm hmm]. Yeah, umm.. I've still got a lot of family back home.. but they're not immediate family. Most of my immediate family is in the UK [yeah]. So, i'm in touch with my culture, understand it to some extent [yeah], but it's not something i'm totally into.

Okay, and is that, is that a conscious decision or is it something that, that, you know, when you say you're not into, i'm not sure whether it's er, whether you're not into it because you don't agree with it, or because you're not, sort of, that way inclined?

No, look I don't, I don't disagree with anything, umm.. it's just something I felt.. to me, I judge people.. for what they are, be it family or friends [mm] umm, so in terms of my cultural background, whether it be white, brown, black, green, whatever, um... if I get on with you and I like you and we get on well, we'll be . yeah.. we'll talk. yeah? Just because we share the same cultural background [yeah], it doesn't mean that, you know, we're gonna be that close [yeah], you know. It's not something that i'm so into, yeah, um.. there's things that I need.. I normally have common with other friends.. the cultural background isn't one of them.

Mmm hmm, okay. Um.. so is it, how important would you say your cultural identity is to you?

It's important to me in the extent that it's important to my family, but as an individual, it's not important [okay], so much to me. So I wouldn't wanna do nothing to disrespect my culture, but that's more because out of respect to my family.. but it's not something that was so important to me. If is wasn't an issue for my family [mm hmm], you know, it wouldn't be that big a deal for me, yeah?

Yeah, okay. Um, and does it play much of a role in your life now?

Not really, no.

Or has it, has it done in the past? You said your mother was, is religious.

Now, look, there's things I might do. So, I don't eat meat on Tuesdays [mm hmm], yeah? So that's just a, sort of just a cultural, religious thing, and it's not because, you know, I strongly believe it. It's 'cos Mum brought me up that way and said, "look, don't eat meat Tuesdays." Fine, no problems [mm hmm]. Um, I want my kids to understand the family background.. I want them to understand where their roots are from [yeah]. But, again, i'm probably not the best person to give that advice, given that I don't know that well myself. But I don't want them to be completely sort of tied off from their identity. Um, so there are certain things I do

do. Um, certain places I will go [hmm], but it's more out of respect to the rest of the family than something I really believe in it myself.

Yeah, yeah, sure. Um, so does it have much of an inf.. influence on any aspect of your life?

I don't make day to day decisions based on my culture, umm, there are things, be things I do, there'll be celebrations that we celebrate as a family together [mm hmm]. Um, but if you ask me details about who, how, why, do you understand about the background, i'm pretty ignorant to it all to be honest.

Okay. Um, and considering obviously, your Mum was religious. when you say you're ignorant to your background, is it something that um... how did that come about?

Umm.. ignorance is probably, again, its a really strong word, right? Um, so I wouldn't say i'm completely ignorant, but I don't totally understand all the details of the background, yeah? Umm... its, its one of those things like I went to India a lot when I was younger umm.. and, I can communicate in the language.I can't speak it fluently [yeah], but I can communicate, but it wasn't top of anyone's priority list. Mum, Dad were busy working [mmm], umm.. you know, I learnt what I learnt. There were certain things that they really focused on, like these festivals, these days. Don't eat meat for this period of time.. and.. you do things out of respect to the family [yeah]. It's not really because you totally understand the reason why.

Yeah. No, that makes sense. An did you talk about culture in your therapy [No]?

No? Umm, do you think it might have been helpful to talk about it?

Not.. the only way it could probably help is [yeah], because there's probably a greater um.. negativity towards any sort of addiction [right] within the Indian or South Asian, I guess as you put it. community. Um, so whereas in other communities it might be more, you feel more comfortable talking about it [yeah], though its kind of like a hidden stigma, you know [yeah] you get this thing attached to you, so you feel more comfortable when you talking about it if you were from a, a different cultural background [mm hmm], but within us, you know, this whole sort of shame on yourself, shame on the family, that plays a big part. So it's something you want to avoid if you can [yeah]. I mean that's another reason why the individual sessions works better than whole group sessions.

Yeah. And is that something you've experienced, that sort of stigma?

Again, to me it's not a bigger part, right, so.. I probably have done. You know, people might see me slightly differently, umm. But again, I've not really opened up to that many people, so I've not said to my friends "oh, look, this is what I do." They've got a certain level of respect for me for who I am.. I don't wanna tarnish that umm [okay].. so, but immediate family yeah probably, probably so.

And how was it umm, so you're immediate family know. How did they take it?

Umm, again its a tricky one. With the counsellor, with the therapist sorry, the whole, the benefit was, they've got some background, so they've got some understanding of the history behind it, and how it might happen and what you need to do... In terms of the immediate family, especially parents. they're from an a) a different, they're more, I don't know, not different cultural, same cultural background, but they're more into it [mm hmm] and a different generation so they can only, you know, there are certain things that they'll hear about, and like "oh my gosh," you know um, and they'll do what they can. They'll do what's right, but it might not always be right. So they might. You're probably, you there. You wanna

get the balance and be there. They'll probably take it to the next extreme and be completely the other side [okay]. Umm, so you know, stop this, stop that, stop that, stop that, don't do this, don't do that.. umm and they'll do what they think's right, 'cos obviously they want best for their kids, but it might not always be the best for you [mm] umm, and you know, sometimes not talking about it is a way for them to avoid it [yeah]. So there might be periods where they don't avoid it, or there'll be periods where they'll go completely into it. There's not that right balance where we just, just sit down and talk about it properly.

Yeah. And do you think that's a cultural thing? I don't think its a cultural thing or generation thing. I'm sure culture has some. Look, my Dad has other people who have had similar problems, but they're his friends, so it's slightly different, right? Um.. but there is the whole sort of keep it behind closed doors, you know. You don't wanna be stigmatised as an addition, a gambler, whatever [mmm], so if you can keep it quite, keep it quiet. So from that perspective, you know, my parents don't go around and say, "oh look, he's got a problem, he's got a problem," umm, they prefer for it to go away [yeah], which obviously every parent would do [yeah]. Umm, but it was something they didn't want the family or myself to be tarnished with.

Mm hmm, okay. Umm, and do you think.. did you find any conflict between your culture and therapy? So you talked about a stigma.

Yeah, um... I don't know if I did. Only the fact that, look. It wasn't a culture thing, it was more like, i'd rather keep it. The thing about drink or drugs, if you've got an addiction there [mm hmm], it sometimes it can be quite obvious [mm], by your behaviour, by your physical outlook, you know, things might change. With gambling its slightly different. psychically you won't change that much. Mentally, you really can [hmm] umm. SO whereas if I was a drunk or a drug addict, even if I wanted to hide it I couldn't hide it. With gambling, it's a lot easier to hide. So from my perspective I want to continue to keep it hidden [mm hmm], and that maybe causes. That's probably more dangerous, 'cos if you've got a drink or drug problem, people see it very obviously and it would be like, right we need to do something, we need to do something. With gambling, umm, because it's a mental thing [mm], no-one can see the difference unless I go openly say look "i've got a gambling problem [yeah] umm, its something which I can keep quiet quite easily. From my perspective, I wanted to continue to do that, and that's not a cultural thing as such, that's more my own sort of preference.

Yeah. Okay, yeah. Umm, and is there anything that might stop South Asians from going to therapy?

Embarrassment, umm.. failure to admit that they've got a problem umm... inability to open up [mm] umm... I think those are probably the main things. Scepticism about what they might experience there [yeah]. 'Cos, again, my first session with gamb.. And again, I think every gambler probably thinks the same right, when you are in a room with other people, you think "oh my God, i'm not as bad as him. Oh my God, i'm not as bad as him," yeah. And that was my, that was my, my, my perception for twelve years ago [mm], you know. I'm quite well educated, i've got quite a good job, I can't relate to these guys. And maybe there's the other eleven guys in the room probably thought exactly the same about me. So.. maybe, I dunno, there's a certain perception that you have, where you think "I don't wanna do it, that's not gonna help me." Yeah? And that's what put me off going to any of these sessions for quite some time [yeah]. Umm.. but the sessions that I had on a one on one were a bit different.

Yeah. Okay. Um... so if you knew before what you know now about therapy, is there anything you would do differently.

Probably would have gone sooner [yeah], not waited so long. Umm... Look, the whole scepticism, you know, I would have been a lot less sceptical about what I did [yeah. Yeah? I

meant, I wasn't negative towards it, but I was doubtful umm, and I needed encouragement to sort of, look, here's something you can do, why don't you go do it. Whereas if I knew what I know now, beforehand. Maybe five years ago, I would have actively gone out there [sure], and tried to find it myself [yeah], and go myself without needing that prompt.

And so i'm curious to know, how did you go.. start.. decide to go to therapy?

I was gonna go somewhere. My sister, who also works in the medical profession. She's a doctor umm, she found out about these sessions on the NHS, and she's the one that told me about them.

Okay, yeah Okay, so that was after that you disclosed it to her.

After I discussed it with my parents [yeah], my parents discussed it with her [yeah] and then xxx she kinda mentioned.

So how long before you, err told your parents. Did that have anything to do with coming to therapy when you, when you did?

Umm.. look, my parents knew I gambled. They didn't know to what extent [no]. They then knew it was a bit of a problem.. umm.. and again, its one of those things which is easy to deny, when it's not in your face all the time. so if I went home and I was, you know.. always drunk- they'd be like "jees, this, this guy needs to be sorted out" [mm] but, if you go home and you behave normally, and you act normally and physically you're the same [mm hmm], you know mentally it might be in my head. From their perspective, you know its not really there, its not really a problem [yeah]. Yeah? Eventually they realised, look, financially this isn't a good thing for him. Uhh, mentally it's probably not a good thing for him. Err, his behaviour has changed slightly, so let's do something. Umm, that's when my sister got involved. But then again, there's a bit of a pause, a bit of a break between. So, initially they tried to do their own.. put their own controls in place, so do this, do this, do this and we went to the next level.. umm.. and to be honest that didn't really help [okay] umm, then my sister found out about these therapy sessions, so she must done some sort of er, I don't know, researched it or something and she kinda found out that there are these sessions which are one to one. We don't need to go to group sessions, which I am a bit sceptical about going to [yeah], give it a go.

Yeah, yeah? Okay, so it sounds like your family was quite supportive in helping you find, seek help.

They are. Look the, they, they're, they're very much supportive, umm, they very much do what they think's right. It might not always be right, but they do what they think's right.

Mm hmm, mm hmm. Okay, um, and is there anything you'd like to add or talk about that you think might be relevant about either your gambling, or your culture?

Mm.. no, all i'd do is just reinforce the fact that... no-one wants to be tarnished with a certain reputation, especially a negative reputation uhh, but it's even more so within the Indian community, the Indian culture [mm]. There's the whole sort of, you know, what will they think, what will they think, what will they think, yeah? Um.. gambling is one of those things, which you can get away with for a very long period of time without nobody noticing [mm]. And you can have a very serious problem, and no-one's gonna know umm.. and.. it's not always so easy to, open up and admit that you've got a problem [mm hmm]. So for a lot of people within our community.. it's something which they have an addiction to, because I see all these stats about how many people have got an addiction. I'm sure if they did the analysis properly, you'll see a very large number of Indians have got a similar problem [mm], but

because you can do it behind closed doors on yourself, without nobody noticing [mm hmm], those stats maybe do not totally reflect the true situation.

Sure, so how do we reach out to those people, do you think?

Its tough, look, these one to one sessions, if you can promote them a bit more. Because I didn't know about it that easily. I know about Gambler's Anonymous where you go in front of twelve people and you speak to people who may be similar, but to be honest, I don't feel that comfortable talking to [sure]. Umm.. I knew about those sessions for the last ten sessions, I didn't know about these one to one therapy sessions [okay. Especially the ones that are on the NHS, only the ones you pay up to a hundred pounds a session for. Um, and again I guess its getting that balance right 'cos I guess if every single addict came to the NHS and said, "i've got this problem," and.. the numbers that.. probably are out there really came through.. there'd be quite a lot of people coming through [yeah], and probably not a long, not enough people to deal with it. And I know that, even for me, the waiting time was quite long [mm] umm.. so.. most people would be more comfortable talking in that secret room [yeah], to that random person who you don't really know, rather than twelve people who might go to that session, and you might bump into someone that you might sort of know [mm] and before you know it, jees, everyone knows about it, yeah? Those kinda things might help umm.. but it's a hard one because, no, nobody wants to disrespect their family, nobody wants to be tarnished with certain reputation. Times that by ten, its what you've got within the South Asian community.

Mmm, okay. Great. Thank you.

That's okay.

Thanks so much.

CBT

Therapy helpful

Talking regularly + openly

Way brain thinks / mind

Educational

Secret + closeted - worried about what

Easier going up to stage - ppl think / finding out

Controls to stop impulses

Attending makes you put into practice - active to step by step process

Theory reinforced

Doing things simultaneously to help reduce

CBT Principles

Triggers

Controls in place

Allow time to pause

Format

Individual better to avoid shame

Group uncomfortable - one in 4/1

Disclosing to lots of ppl as opposed to a secret room

Before therapy

Initially skeptical

Not sure what to expect

anyone? Personal talks to someone unknown

- Can they help - knew they already

Can't relate to ethnic background - forcing negative gambling

Am I going to connect

Nothing to lose

not expecting / ready to stop - still going to gamble

Wanted a man - more comfortable - more open - sports / industry

Perception man understands more about sports.

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Therapist

non judgemental

understanding

Important for therapist to be outsider

A specialist in gambling - meaningful

Made feel comfortable

2 way conversation

listened, not just advice - balanced

flexible, able to deviate from content

Not generic + just listening

Could not fully relate to sports betting but could apply the theory

Flexible with timings

Advice to others

Needed encouragement something can do

Prompt to find out

(Sister in medical profession found out)

Promote 1-1, NHS might not handle no.s > long waiting list

~~SA commit x10~~

~~Advice~~ Coming to therapy

2 way process

Individual to utilise advice

himself { Need to replace therapy with something - fear of judgement from ppl I know

Still need to work

Keep open mind

Nothing to lose

Not many preconceptions / L sceptical / negative / doubtful

Go sooner

CULTURE

Bias + help seeking

Denial

Embarrassment

Need to be in secrecy

Not comfortable opening up to friends + family

Inability to open up

Scepticism of therapy

Perception (in group) better / minorities / can't relate

perception different

Bias + gambling

Negativity towards addiction

Hidden stigma, harder to talk

Shame on self + family + disrespect

Not told many to maintain respect from others

Hidden not to tarnish - x10 in SA - easier not to challenge

Keep behind closed doors - dangerous as noone will know - easier to hide

Prefer to go away

- Other addictions obvious, gambling mental

Worried about what others think

Stats inaccurate as happens behind closed doors.

Background

Not really religious

Mum + wife are

In touch + understand

Not 'into' - properly not into it?

Adheres to customs as brought up like that - festivals - meat free days

Would like kids to understand their identity

Important = to family + respects that - not believed himself necessarily

Does not really understand it - w/o understanding why

Speaks language

Not top priority growing up

Parents react strongly as entrenched in culture / diff. generation

↓ Do what can but not always right - extreme reactions, think easy to stop

Do not talk, avoid, not sit down

Supportive family

Meaning to him - persuade - background made him feel too much emphasis on this

Does not judge on race or culture

Strong background ≠ closeness

Not something identifies with others - defensive?

No day to day decisions culture based

Characteristics - Illusion not too bad to save face to parents

10 years gambling - Not forthcoming with disclosing behaviours or gambling habits

No environment w/ F&F to be open. Own preference to keep it hidden - doesn't recognise the cultural reasoning? Talks about family, but does not make connection, recognises hiding could be dangerous.

Gambling became more controlled