IFF Research

Building Knowledge of Women's Lived Experience of Gambling and Gambling Harms across Great Britain: Phase 2

University of BRISTOL

GamCare

The existing gambling and gambling harms evidence base tends to focus on men. Research to date shows that women experience gambling in different ways from men, specifically in relation to the types of gambling they participate in and their motivations for doing so. It is therefore important that future research on the lived experience of women in relation to gambling is analysed through a gendered perspective rather than comparing the behaviour of women against that of men. Research focused on women's experiences of gambling has increased over the last decade but a limited understanding about the experiences and behaviours of different groups of women, how this varies by demographics and geography and how this relates to wider determinants of health remains.

GambleAware commissioned a consortium of IFF Research, the University of Bristol and GamCare's Women's Programme to build knowledge about why women in Britain take part in different types of gambling, the effect this has on them and their lives, and their experience of support and treatment services.

The research approach is iterative, across three phases, with each phase flexibly adapting to emerging insight from the phase before. In Phase 1 (completed in 2021) we mapped the landscape via interviews with Expert Witnesses in the field (for example, service designers, deliverers, researchers and policy stakeholders), experts by experience, including women who gambled and who were affected by others who gamble, and conducted a rapid review of literature on the topic. In Phase 2 (the focus of this summary) we explored the views of women in Great Britain experiencing gambling and gambling harms using a combination of individual depth interviews and a five-day long online community. In Phase 3 we will share findings with Experts in the field, including Expert Witnesses involved in Phase 1, and explore potential support responses. Figure 1.1 summarises the approach.

RESEARCH APPROACH

INCEPTION

Inception workshop, incl. stakeholder mapping

July 2021

1: MAPPING THE LANDSCAPE

16 expert witness interviews and roundtable with 7 gambling experienced women

Rapid evidence appraisal of 75 research, policy and practice

August – November 2021

2: UNDERSTANDING CONTEXT & NEEDS

Depth interviews and an online community with women with experience of gambling and women affected by gambling, reaching the views of 72 women

Secondary analysis: Gambling Commission's quarterly telephone survey, and GambleAware's 2020 Treatment and Support Demands Survey data

December 2021 – June 2022

3: BRAINSTORMING SOLUTIONS & FINAL OUTPUTS

2 workshops with 12 new and reconvened expert witnesses

A community select committee with 12 experts by experience; women

July – December 2022

OUTPUTS

- Project Initiation
- Document summarising any scope changes

- Summary note on findings and implications for Phase 2
- A peer review submission

- Summary note on findings and implications for Phase 3
- A peer review submission
- 5 visualised participant journey maps

- Findings presentation with embedded audio/visual
- Final report
- Synthesis report
- A peer review submission

This summary builds on the findings from Phase 1, summarises Phase 2 findings for each of our research questions and discusses the implications of these findings for Phase 3. As this summary presents emerging findings, content is subject to change following further refinement of analysis and triangulation of evidence during the final analysis phase of the project. Evidence for Phase 2 comes from three sources combining qualitative and quantitative elements[1] :

- Depth interviews with 35 women (16 who regularly or previously regularly gambled; 11 affected others who did not themselves gamble; and 8 affected others who did gamble), carried out in March and April 2022
- A five-day online community with 34 women (19 who regularly or previously regularly gambled; 15 affected others who did not gamble) carried out in April 2022
- Secondary analysis of the most recent wave of the GambleAware Treatment and Support Survey, the fieldwork for which was conducted in November and December 2021

It's worth noting that qualitative approaches enabled us to explore the contexts, causes and impacts for women in real life, while quantitative elements helped explore the prevalence of attitudes and behaviours that were identified from qualitative research.

For the qualitative elements, most women recruited as current or former regular 'gamblers' (but not affected others who also gambled) either self-identified as having experienced harm from gambling, or due to their short-form PGSI scores were classified as potentially experiencing negative consequences.

Alongside this summary, we present five 'journey maps' which draw on common themes emerging from the qualitative research to show how different life events and stages interact with an individual's gambling experiences. The journey maps are composites, in that they do not represent one person's story in the same manner as a case study, but instead try to present a broader picture of the findings by bringing together key findings from multiple narratives, whilst protecting the anonymity of our participants. We describe how the journey maps were created in Appendix 1.

1] Please see Appendix 1 for more detail about the methodology for Phase 2.

WHAT IS THE ROLE OF GAMBLING IN WOMEN'S LIVES?

The Phase 1 summary noted that little is known about the experiences of women who gamble or are affected by others who gamble in Britain. It provided evidence that there are gendered differences in how women and men gamble, both in product type and in how they gamble. It also highlighted some statistics [2] about levels of gambling harms experienced by different subgroups of women and noted the importance of understanding the dynamic and changing nature of women's gambling practices and guarding against outdated gendered stereotypes.

Lived experiences of gambling: Women who gamble

Women's early experiences of gambling

Among the women we spoke to as part of the online community and the depth interviews in Phase 2, positive childhood experiences and positive associations with gambling were the most commonly described early experiences of gambling. These positive experiences were 1) whole-family experiences (such as getting together to bet on the Grand National and/or visiting arcades as part of childhood holidays) or 2) bonding with a parent, usually a father, as part of that parent's out-of-home gambling. In both types of experiences women recalled actively participating in gambling as children, for example by choosing a horse to bet on or given money to play slot machines.

When describing these early experiences, women often used language such as "fun", "nostalgia" and "excitement". They celebrated wins (for example, by spending winnings on a family meal or other treat) while considered losses as unimportant, although a few women did recall negative aspects of family gambling behaviour, such as arguments between parents about amounts spent. Thus, women's early experiences of gambling positioned gambling as a normal activity, with few downsides. This framing typically persisted through to adulthood and provided the lens through which adult gambling was initially viewed as a normal, fun, harmless activity.

The examples shared by women of different groups differed somewhat. Black African and Black British women in our sample tended to share fewer experiences of engagement with gambling as children.

Women's experiences of gambling in adulthood: gambling with others

Regardless of their childhood experiences of gambling, most women in the qualitative research reported that their first experiences of gambling as an adult involved a social aspect, for example, some form of gambling with family, friends or work colleagues.

Those who gambled outside of the home at bingo or casinos tended to do so in an all-female group or with one other woman such as a best friend or mother. Women often described these as "girls' nights out". This type of social gambling was usually undertaken on a regular, planned basis, typically weekly. Women often described drinking alcohol as part of the experience. Several women attributed alcohol-consumption as a trigger to spend more money than they had planned but described their feelings about this more as a frustration than a serious worry or issue.

Less frequent, one-off occasions such as a major sporting event or being on holiday could also function as triggers to gamble with others, particularly for those who had done so with family since childhood. Horse racing events such as the Grand National or Cheltenham Festival were most commonly mentioned. These were framed as "family traditions," where the event itself and the excitement of watching it on TV with the family (usually in the home but occasionally in a pub) were core parts of a shared family experience. Women emphasised these aspects over and above the gambling aspect, which they viewed as secondary to a fun tradition.

[2] From the previous wave of the GambleAware-commissioned Gambling Treatment and Support Study conducted in 2019.

Women's experiences of gambling in adulthood: gambling alone

Some women gambled alone, usually in their own home. This was rarely their first experience of gambling – gambling alone typically happened as their gambling escalated, so while some gambled both socially and alone, others moved to solo gambling as an alternative to social gambling.

Scratch-cards and online gambling, often via an app on a smartphone or tablet, were the most commonly mentioned activities among those who gambled alone. The convenience and availability of gambling apps was a commonly cited reason for moving to gambling alone, and for continuing to do so. Some women started to gamble online alone whilst venues were closed during the pandemic, which they maintained as a habitual behaviour after lockdowns were lifted. Convenience and the potential for 'impulse purchases' were also motivations for playing scratch-cards, which remained an option during the pandemic because they can be easily purchased as part of a grocery shop, or at a petrol station.

Online slots that offered daily "free spins" were particularly popular among women , with this incentive reportedly a trigger to gamble more frequently, so as to not 'miss out'. The frequency of gambling alone varied but overall, women who gambled alone did so more often than those who gambled socially, typically ranging from weekly to daily.

Women who gambled alone did not do so at any set time of day, or any set day of the week. Rather, patterns of gambling differed by individuals, based on their circumstances.

Some women gambled at whatever time the gambling afforded them the most pleasure, whether as a "lift" to start the day, or as a means to unwind in the evening. Others gambled when they had the time to do so, which varied based on their work and personal schedules. Those with children often waited until after their children were in bed. Others only gambled alone at weekends – this was either because they were betting on sports events that happened over the weekend (for example, horse racing, football) or because it was seen as an end-of-week reward.

Women's experiences of gambling in adulthood: subgroup analysis

GambleAware's Treatment and Support survey suggests some differences in patterns of gambling behaviour by demographics, however, these differences are relatively small. It is therefore not surprising that we did not see these differences in the qualitative research. The survey data shows that C2DE women, and women with childcare responsibilities were slightly more likely to have gambled in the last 12 months and when they have gambled, for these products to be scratch cards, bingo, or online casino games[3] .

There were also differences in frequency of gambling observed from the quantitative data, with older women (55+) and women in relationships being more likely to gamble more than once a week. Perhaps unsurprisingly, women with a PGSI score of 8+ were over three times more likely to gamble once a week or more, compared to women with lower PGSI scores of 7 or less (66% vs 20%).

Women's attitudes to gambling and use of language when discussing gambling

Different factors underpinned women's attitudes to, and experiences of, gambling in adulthood. Some women, particularly those who had not experienced gambling harms (but including some who scored 1+ on the short-form PGSI) described their adult gambling practices as a harmless social pastime, provided that their gambling did not cost them more money than they could afford. They felt that discussions around 'problem gambling' were less relevant to them and felt that any links between their gambling and other addictions was not applicable to them. Overall, majority of these women described their gambling activities as being positive and socially acceptable leisure activities.

Few described their behaviour using the umbrella term, "gambling". They instead used language that described either the specific activity (for example, "getting my free spins", "placing a bet") or the occasion ("going to the bingo").

These findings reflect and extend Phase 1 findings, which also found that women may regard their gambling practices as a social pastime, and therefore dismiss the discussion of 'problem gambling', or 'harmful gambling' as not relevant to them. The findings above therefore highlight the need for any future support services to carefully consider how to target women who are at the risk of harm from gambling in terms of both messaging and language.

[3] 58% of C2DE women participated in gambling in the last 12 months compared with 54% of ABC1 women. Amongst women with responsibility for children, 61% gambled in the last 12 months, compared with 55% of those without responsibility for children. These findings, and all quantitative findings within this report are statistically significant at a 95% confidence level.

Lived experiences of gambling: Affected others

Affected others' early experiences of gambling

In the Phase 2 qualitative research, women affected others reported a variety of childhood experiences with gambling. Three broad types emerged. First, affected others who also gambled themselves often had similar positive childhood experiences to those described by women who gamble and a similarly normalised view of gambling. However, their subsequent experiences of gambling harms as a result of someone else's gambling made them less likely to idealise early experiences and to realise that excessive or uncontrolled gambling could be harmful. Second, there were affected others who experienced gambling harms in childhood (usually from a parent or close family member), which drove their decision never to gamble. Finally, there were affected others who had no experience of gambling until adulthood, then suffered harms as a result of another adult's gambling (usually a partner).

Affected others' experiences of gambling in adulthood

Affected others who did not gamble primarily experienced gambling in adulthood in terms of the gambling harms they suffered. These will be further discussed in a later section of this report.

Affected others who also gambled tended to do so both socially and alone. Affected others who gambled socially with other people tended to gamble quite regularly, whereas the frequency of gambling for those who gambled alone was variable. The main difference was in how they maintained control over their own gambling, and in their self-awareness about their gambling behaviour. This involved both setting hard financial limits for themselves (for example, amounts per gambling occasion or per month) or setting lines they did not cross – for example, frequency of gambling (for example only gambling at weekends) or gambling type. Seeing the harms that could be caused by harmful gambling seemed to prompt them to examine and question their own gambling behaviour in a way that was less evident in women gamblers who were not affected others.

Affected others' attitudes to gambling

Whether or not they gambled, affected others did not tend to express negative views of gambling, unless they had experienced more severe gambling harms – for example, experiencing financial losses or serious mental distress as a result of a partner's gambling or witnessing one parent experience harm as a result of the other parent's gambling. Although most expressed views that the gambling industry could do more to safeguard and support people experiencing gambling harms, they placed responsibility for harmful gambling with the person who was gambling, rather than with the activity itself or industry practices.

Attitudes to gambling were more negative if the person who gambled was a partner, and they were unaware of their partner's gambling before beginning the relationship or if the gambling had developed during the relationship. Women for whom this was the case tended to have more negative views about gambling, particularly if their partner's behaviour had caused more pronounced harms – for example, mental distress due to secrecy and lying, or serious financial harms.

WHAT ARE THE DRIVERS OF GAMBLING AMONG WOMEN?

Evidence from Phase 2 confirmed that the drivers for gambling among women in Great Britain match those outlined in the wider literature considered in Phase 1: Psychological Drivers; Social Drivers; Financial and Economic Drivers; and Industry practices. Importantly, these drivers typically interact, and an individual may have multiple motivations for gambling across different drivers.

In the qualitative research, women who gamble commonly reported some escalation of their gambling over time, either in terms of increased frequency of gambling, increased types of gambling or increased amounts of money spent. Few women reported their gambling remaining constant over time, or de-escalating.

Psychological Drivers

The Phase 2 qualitative research found that positive emotions associated with gambling often motivated women to gamble, reinforcing the findings from Phase 1. The feelings of excitement described as "the buzz" or "the thrill" were associated with all types of gambling and was a key driver for gambling. This "buzz" appeared to have two components – anticipation before and during gambling as women hoped for a win, which intensified to elation if they actually won. Interestingly, the amounts of money bet or, in the case of a win, the amount won, did not seem to particularly affect these emotions – the potential of any win, and a win itself, were sufficient to trigger these positive emotions. The disappointment associated with losing was typically described as a far less intense emotion than the elation of winning and did not appear to persist for more than a few minutes. (Exceptions to this were when a loss was particularly significant, e.g. a large sum of money or, for those on low incomes, money that had been earmarked for another purpose such as food or other essentials.)

Many women described an early 'big win' when they first gambled, and of feeling huge excitement and elation, as a motivation to continue gambling, also found in Phase 1. Trying to recapture this particular set of emotions was often identified as an important reason women began regularly gambling as adults, particularly for those who already had positive childhood experiences of gambling.

This was also a primary driver in continuing to gamble over time. This was true even when the emotions dulled – this dampening could trigger an escalation of gambling in an attempt to recapture the positive feelings. These emotional aspects of gambling were an important driver across subgroups of women, and Treatment and Support survey analysis also supports this; 23% of women say they always/often gamble "because it's fun", 18% "because it's exciting" and the same proportion (18%), "because of the sense of achievement when I win".

In contrast to Phase 1, there was less evidence in the qualitative research of women beginning to gamble to 'escape' mentally from negative aspects of their lives, such as stress, grief, loneliness or trauma. Only a few women described these as motivations for taking up gambling. However, using gambling to escape was identified as a factor in gambling escalating over time. This emerged as a factor for some women with caring responsibilities, whether caring for children or parents. Additionally, a handful of women discussed periods of trauma, and identified that this was, for them, linked to increased gambling as a means of psychological escape, although this was not a universal experience amongst women who gambled.

While boredom emerged as an important reason women continue to gamble, it was not commonly cited as the reason they first began to gamble as adults. Women who said they spent a lot of time feeling bored were more motivated to seek out the fun and excitement that gambling provided them.

The pandemic was identified as a key reason for women feeling more boredom than they had previously, particularly during lockdowns, and a reason for some women's gambling escalating during this time. However, analysis of the Treatment and Support survey shows that only 7% of women identified with the statement that they gambled to 'escape boredom/fill their time'. Suggesting that, at a population level, this is less of a driver to gamble than other factors.

Women in the qualitative research who experienced health problems (particularly mental health problems but also some physical issues or disabilities) sometimes expressed more negative reasons for starting to gamble (for example, to escape trauma or boredom) rather than describing the 'in-the-moment' feeling of excitement when they gamble. A handful of women who described experiencing and getting treatment for anxiety and depression also said they started gambling to alleviate boredom, loneliness or low mood.

Social Drivers

As discussed when describing women's lived experiences of gambling, gambling can be a means to develop and maintain social connections, meaning that women who gamble with friends often perceive gambling to be primarily about socialising and do not differentiate the two activities, This social aspect of gambling seems to play an important role in normalising gambling activities, as seen in Phase 1 findings.

Familial and friendship influences, particularly around normalising gambling and downplaying negative impacts due to positive childhood experiences, also emerged as a strong driver to gamble as an adult. This finding emerged more strongly than in Phase 1, particularly in terms of fathers building bonds with their daughters and introducing them to gambling.

Some women mentioned that they had only started to gamble regularly as an adult after being invited to a gambling venue such as bingo or arcades by work colleagues or family. Positive experiences at such events triggered the desire to continue gambling.

Similarly, reading social media posts about wins could also motivate women to gamble more. Although participants acknowledged that people tend to post more positive experiences on social media and were probably not posting about their gambling losses, this could still trigger a desire to gamble.

Financial and economic drivers

The attraction of winning money motivated some women to gamble, similar to what we found in Phase 1. This could be from an initial big win themselves, or even from hearing stories of others having big wins. This is supported by survey data, which found that 56% of women always/often gamble for the chance of winning big money. However, while the idea of winning money was motivating, Phase 2 qualitative findings suggest that this was rarely the only reason, or even the primary reason women said that they had started gambling – instead, it was most likely to sit alongside the psychological and (sometimes) social motivations previously discussed.

In terms of escalating gambling, financial loss could lead to increased gambling as women tried to recoup losses. However, the actual amounts gambled could vary and were not often reported to lead to women suffering serious financial harm.

In contrast to Phase 1 findings, there was little evidence in Phase 2 to support the idea that women started gambling because they hoped to win enough to physically escape from a poor financial situation or poverty (although it should be noted that low-income women, although included in the sample were not a specific focus of the study). Being on a low income was, however, mentioned by some women as a reason for gambling less due to having no spare funds, but this also triggered others to gamble more, in the hopes of spending a little and winning more.

Industry practices

Phase 1 suggested that an important driver for women to gamble was the impact of marketing, particularly gendered advertising. In Phase 2, this did not emerge as a driver to begin gambling but was noted as a contributory factor in many women continuing to gamble, gambling more often, or diversifying to try new products/modes of gambling. Some women noted that seeing advertising about gambling could trigger a desire to gamble and further normalise gambling, and as such it sits between being an industry practice and a psychological motivation.

Gambling operators offer incentives that allow players to gamble “for free” (for example, sign-up offers or “free spins”), or other financial incentives and special offers. In our sample, these incentives often provided strong motivation to continue to gamble for women who already gambled online. A few women who had moved from in-person gambling to online gambling cited these as the trigger to first try online gambling. Women saw these offers advertised both on TV and online and a small number of women mentioned seeing them in bingo halls for example on the back of toilet stall doors.

Increased accessibility of where and how to gamble led some women to gamble more. The proliferation of online gambling, particularly apps, mean that women can now gamble from anywhere on a smartphone, tablet or computer. New technology in bingo halls, with pencil/paper bingo being replaced by touchscreen consoles was mentioned by a few women as a motivation to spend more money while playing, as they had to concentrate less and could play “multiple lines”.

Replacing cash with bank cards or electronic payments made it more difficult for some women to keep track of exactly how much they were spending (both in person or online), and also made it more difficult to set hard limits on how much they would spend.

Risk factors for harmful gambling

Phase 1 identified six main themes regarding risk factors for gambling harm in women, namely poverty, domestic abuse, parental influence, perceptions of gambling risk, gambling practices and industry practices. Below we explore the extent to which these factors were evidenced by women who gamble during Phase 2 and share some newly identified risk factors for why women become more vulnerable to harmful gambling. It should be noted that some of these factors can be factors can be influential in terms of both influencing participation in any type of gambling, and towards harmful gambling behaviours.

The six areas previously identified were:

- **Poverty:** Phase 1 findings suggested that gambling can be associated with poverty indicators and that people living in impoverished areas are found to be more vulnerable to gambling problems than those in affluent areas. Whilst this may be true as a trend at a population level, Phase 2 qualitative findings revealed that it is hard to draw correlations between levels of income and gambling habits as some women gambled because they had spare disposable income, others gambled because they had very little money and were trying to win more, while others restricted their gambling due to lack of available funds.

- **Domestic abuse:** In our qualitative research, whilst women did not talk directly about domestic abuse, relationship difficulties, high levels of conflict and breakdowns were cited by some women as a key cause of gambling escalating to become harmful.

- **Parental influence:** This was strongly evidenced by findings in Phase 2 as the majority of women from both the online community and depth interviews were first introduced to gambling as a result of a ‘bonding activity’ with their family and grew up watching their parents and other family members gamble.

- **Misperceptions of gambling risk:** Many women downplayed the risks of gambling by placing high importance on the social benefits they accrued from it. For example, women perceived in-person bingo as a ‘social night out’ rather than as ‘gambling’ per se. Some gambling practices were seen by women as less risky and harmful if they involved a social element. Bingo was the most commonly mentioned type of activity, but a few women also mentioned gambling at arcades. Any gambling done as part of a holiday was also deemed less risky – again, slot machines at arcades were frequently mentioned. Other types of gambling perceived as less risky included ‘free’ gambling such as online ‘free spins’, although only if this did not act as a gateway to spending money in an online casino.

- **Gambling products:** As elaborated in Phase 1 findings, certain types of gambling were linked to gambling harm in women, such as online casinos and EGMs. However, opinions varied as to which practices were deemed riskier among women in Phase 2. Generally, findings from qualitative interviews and the online community revealed that EGMs, casinos and bingo online, scratch cards and online sports betting were commonly cited by women suffering from gambling harms.

- **Industry practices:** Phase 2 identified strong motivations among women to continue gambling/take up new gambling products as a result of advertising and industry incentivisation for instance, use of free bets for first gambles and promotion of cashback sites during online shopping. Some women also mentioned the strategic positioning of scratch cards by tills making them an easy impulse purchase.

Below are some newly identified risk factors from Phase 2 for why women become more vulnerable to harmful gambling:

Risk factors that may cause escalation into harmful gambling

- **Increase in spending beyond affordability due to gambling gratification:** Women recalled gradually increasing the amount they spend on gambling due to the 'high' and 'rush' of winning as a result, sometimes losing track of their expenditure and becoming more vulnerable to suffering financial harms, if they spent more than they could afford.

- **Diversification of types of betting and gambling:** This was common where set patterns and habits for example, going to the casino once a week, were diversified and newer gambling activities such as online bingo or scratch cards were adopted. Many women described this happening during lockdown when they had more free time and were therefore able to explore online betting activities.

- **Trauma/Stress:** In many instances in the qualitative data, gambling was seen as an 'escape' for women dealing with trauma and other stressors in life, such as, illness or loss.

- **Spending more time at home:** Tying in with the point above and especially prevalent during lockdown, women described finding themselves with additional spare time and choosing to adopt new gambling habits that resulted in more opportunities to gamble. This was also common among women spending more time at home due to furlough, caring responsibilities for their young children, or long-term illness.

o The role of potentially life-limiting health conditions in vulnerability to harm is supported by multivariate analysis of the Treatment and Support Survey data, which found that women with Chronic Obstructive Pulmonary Disease (COPD) or diabetes were 2.9 times and 2.1 times more likely to have a score of 1 or more on the PGSI compared with non-gamblers.

- **Consumption of alcohol:** Women who described consuming alcohol frequently or 'excessively' felt more vulnerable about crossing the threshold of safe gambling, especially those who saw gambling as a social activity and tended to use it as a gateway for social drinking.

o The multivariate analysis showed a link between the number of units of alcohol consumed per day, in that heavier drinkers were 2.6 times more likely to have a PGSI score of 8+than non-drinkers. Similarly, women who smoke were up to 3 times more likely than non-smokers to have a PGSI score of 8+.

Protective factors

A few women described using techniques to ensure their gambling was under their control and did not escalate into harmful gambling. These were often affected others who also gambled and who had seen first-hand the impacts of harmful gambling. One of the most common techniques described was having someone close to them that they didn't feel "judged by" to open up with about their gambling habits and any harms thereof. For these women having an outlet helped them become more self-aware of their gambling behaviours which in some instances, helped keep it under control.

Another technique mentioned was having personal rules and thresholds either in the form of mental steps such as not going beyond a set limit on gambling spend for a week/month, or more physical controls such as card blocks and limits on their online accounts.

A less common but equally effective technique mentioned by some women was keeping themselves busy and distracted for example by taking up hobbies, signing up for gym/other classes etc. so as to not fill their spare time with more gambling. This was especially true for women that were actively looking to change their gambling habits.

Some women also saw borrowing and debt as a line or 'threshold' that they would not cross and described it as their "way of keeping their gambling in check". More specifically, they felt that if they were unable to pay rent and bills and had to borrow from friends and family, they would deem this as "problem gambling."

WHAT DO GAMBLING HARMS LOOK AND FEEL LIKE FOR WOMEN?

We have grouped the harms experienced by women who gamble across the same six dimensions identified in Phase 1: health and wellbeing harms; financial harms; personal relationship harms; reduced performance and productivity; cultural harms; and criminal activity. Findings from Phase 2 build on these categories. Generally, harms identified among women as gamblers and affected others tended to be intertwined in that often some women experienced more than one, or one type of harm sometimes resulted in another. The impact of these harms often varied and the importance of their consequences depended on what else was going on in the women's lives. No evidence was captured at Phase 2 for harms that relate to gambling outside cultural and legal norms. It is also worth noting that for Phase 2 we purposefully over-sampled women who were likely to be at risk of harm (as per the Appendix 1) to understand a breath of experiences of gambling harms.

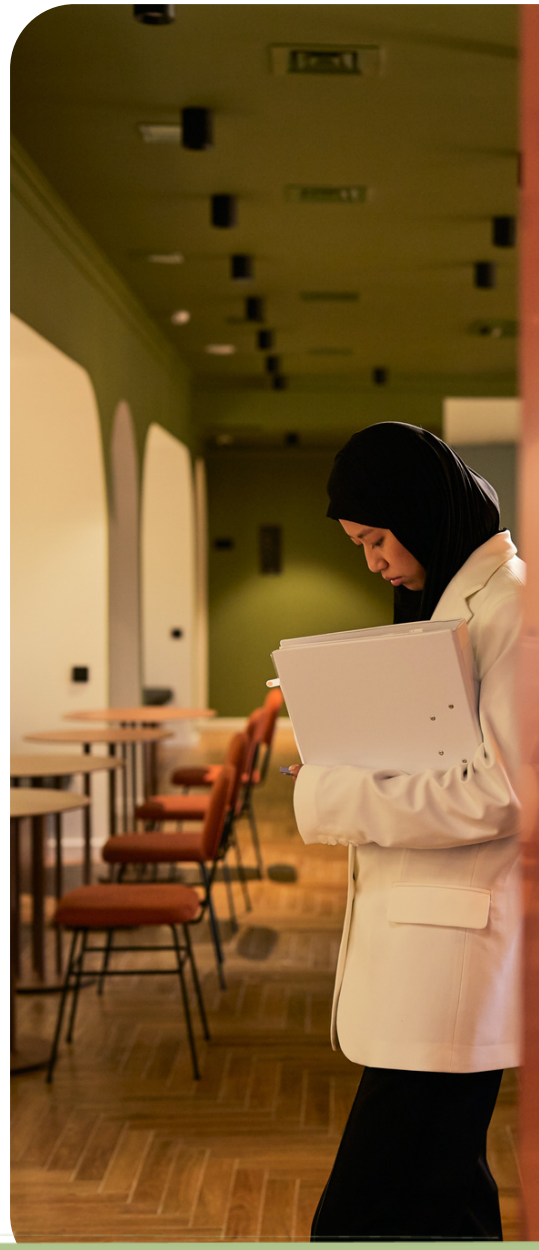
Among women who gamble

Health and Wellbeing Harms

As reported in Phase 1, gambling harms often manifest in harms to mental health and are closely linked to the experience of financial and relationship harms, amongst others. In line with this, 'loss of self-esteem' as a wellbeing harm became quite pronounced in findings from the online community and depth interviews, where women felt a sense of guilt and shame for "wasting money" and "losing control" when spending more than they had intended to. Many women described this as a sense of 'disappointment in self' which strongly reinforced findings from Phase 1 expert witness interviews.

The sense of burden felt by women in having to hide their gambling behaviours and subsequent consequences from their partners and family were a recurring theme in Phase 2. This was seen as a key reason for underlying stress and anxiety, and from the Treatment and Support survey, amongst women who had sought treatment, advice or support, concern or anxiety about their gambling was the most commonly mentioned reason for doing so (18%).

Physical harms such as irritability, loss of sleep and appetite, and stress from having to figure out the finances in the event of gambling losses were found to be quite common across the online community and depth interviews. A less common experience of women we interviewed who experienced a high level of gambling dependency (with a PGSI score of 8+) was suicidal ideation or attempts.



Financial Harms

In Phase 1, impact on individual and family finances for example, worsening living standards for family, loss of savings, borrowing, debt, loss of home in severe cases was highlighted in the REA and the expert witness interviews and the roundtable. In phase 2, survey data shows that financial impacts were the second most commonly cited motivation for seeking help for gambling by women (mentioned by 17% of those who sought help).

A new financial harm from Phase 2 was the 'opportunity cost' of alternative ways of spending the money that had been used by women for their gambling, with examples of using it in the form of more secure retirement plans, holidays abroad, etc. Some women spoke of regret about the other potential ways that they could have spent money that they had lost through gambling, and some considered this to have resulted in negative impacts on their quality of life, through the absence of other things (mainly experiences) that could have brought them joy, or peace of mind.

Reduced Performance and Activity

Although a small number of women mentioned losing jobs, others reported working multiple jobs to be able to afford their gambling habits, which impacted their lives in other ways, for example, through a loss of time for activities outside of work (other than gambling). A few women mentioned taking up gambling as an activity during furlough or while working from home, which was borne out of boredom but escalated into a habit they then struggled to reduce.

Personal Relationship Harms

The strain on relationships from gambling, often due to financial pressures of prioritising gambling above others, was a common type of personal relationship harm expressed by women we interviewed. Women interviewed spoke of spending less time with friends and family because of shame, and because they could not afford to go out with them. They mentioned having to hide the extent of their gambling from friends and family as a result and felt a sense of 'loss of self' from having to conceal a big part of their lives. In the case of one participant this contributed to the ending of her marriage.

There was also evidence of a 'power struggle' wherein women felt a sense of entitlement and agency over their finances and found that to clash with their partner and families' disapproval of their gambling, especially if it involved financial losses.

Among women as affected others

Gambling harms experienced by women as affected others are largely the same as harms experienced by women experiencing gambling problems, with financial and health and wellbeing harms as the most pronounced, and reduced performance, criminal activity, and cultural harms with the least evidence.

Most women irrespective of their background felt the financial burdens and responsibilities of the person whose gambling was affecting them which led to increased borrowing and added financial pressure for them. Women who weren't in permanent employment or did not have a steady source of income tended to experience health and wellbeing, and relationship harms in addition to financial harms. This was often due to the lack of financial independence which either led to borrowing from other friends and family which led to a sense of "shame" and "guilt" in some women resulting in strained relationships, and/or caused additional anxiety and stress as they were burdened with having to figure out a way to financially stay afloat. This was especially apparent among women with shared caring responsibilities with their partner, and women that had financial responsibilities of their family/siblings.

In terms of health and wellbeing harms, women cohabitating or married particularly felt more burdened by their partner's gambling as in some situations their partners tended to offload and share their experience of gambling and gambling harms which impacted their own mental health . For example, one woman recounted how when she was pregnant and her partner would confide in her about his gambling and the financial losses he was incurring, it aggravated her stress and caused sleep deprivation. Generally speaking, in the case of women as affected others, psychological harms as a result of their partner/family's gambling were more pronounced than physiological harms.

HOW CAN GAMBLING HARMS BE PREVENTED OR REDUCED AMONG WOMEN?

Understanding the harms associated with gambling is important for understanding the services and policies needed to prevent and reduce gambling harms among women; the third study objective and the main focus of the forthcoming Phase 3. Our qualitative research expands on findings from Phase 1, illustrating the complexity of self-identification of harm, and the multitude of ways in which the harmful effects of gambling, and acknowledgement of these, can be suppressed, minimised, hidden and rejected by women.

Awareness of gambling harms support

In the Phase 2 qualitative research, women who gambled were often aware of messages about responsible gambling and the availability of helplines, but it was rare a woman could name any organisations behind specific messages or support services. GambleAware, GamCare and Gamblers Anonymous were the most widely known.

Women recalled seeing responsible gambling messages on various channels – for example, television and online advertising, pop-up messages on online gambling sites, in person in bingo halls (often posters in toilet stalls).

However, although they were aware that such messages exist, they did not always pay attention to them or feel they were relevant to them. There were also some women who gambled that were not aware of any help or support available – they did not recall having seen any messages advertising support. Those who did not believe their gambling was harmful, or at least not sufficiently harmful to need support, tended to have lower awareness of messages about responsible gambling or the availability of support.

Women who gambled were usually aware of some tools that could help control and limit gambling. Typically, this was a subset of the following: financial blockers, being able to self-exclude from gambling sites, setting deposit limits, time blockers/ time reminders, and the ability to set nudges in chat sections to remind them that if they were not enjoying playing, they should stop. A few were also aware of support options such as talking therapies, Gamblers Anonymous meetings and residential treatment centres.

Affected others were also aware that support was available for people who gamble (as above) but had lower awareness that support services also existed for those affected by another's gambling. Despite having awareness that this type of support existed for people affected by other addictions (for example, Al-Anon), few had heard of anything similar for those affected by gambling.

Demand for, and access of, gambling harms support

Few women in our qualitative research had actually accessed any formal or informal support for their own gambling. For context, by formal and informal support we mean both support from gambling treatment and support services and support around gambling harms (e.g. debt advice). For those that did, most started informally, by speaking with a spouse, friend or family member, or using blocking tools or other 'self-help' measure. Types of formal support mentioned included a GP, Cognitive Behavioural Therapy (CBT) or other one-to-one counselling and Gamblers Anonymous.

Low proportions of women seeking help were similarly reflected in the Treatment and Support survey, which asked women whether they would like to access treatment, advice or support. Only 4% of women with a PGSI score of 1+ wanted any treatment, and 3% wanted support or advice. The vast majority, 85%, did not want any advice, support or treatment. Only when women's gambling becomes more severe (PGSI score of 8+) did more women say they would like to access help, and even then, only 18% of women wanted treatment, while 7% wanted support or advice.

When considering how many of these had actually accessed any treatment, support or advice, the numbers fell even further to c. 6%.

Some subgroup differences did emerge in terms of willingness to access treatment or advice / support – for example, the survey showed that, among women with a PGSI score of 1+, those who were younger, religious, C2DE, from a Black, Asian and Minority Ethnic (BAME) community or had childcare responsibilities were more likely to want treatment or advice / support. These subgroup differences generally reflect Phase 1 findings.

A regression model shed further light on the groups who are more likely to have accessed treatment and/or support as a result of their own gambling behaviour, demonstrating the strength of some of the above factors:

- Younger women (under 25) were over 5 times more likely than older women (over 45) to have accessed any type of help.
- Those with responsibility for children were almost twice as likely to have accessed help.
- Those from minority religious groups were four times more likely to have sought help than those from the dominant religious groups in GB (Church of England, Roman Catholic, those of no religious affiliation).

However, the more compelling finding from the Treatment and Support Survey is how low these numbers are overall, even for those with a PGSI score of 8+. This suggests there are substantial barriers to accessing support and to wanting to access support; considerable work will need to be done by treatment providers to overcome these. Overcoming barriers to support will be further explored in Phase 3 of this study.

Some affected others had not even considered the need for support for themselves and were focused only on finding support for the person who gambled. These women did not consider themselves a priority for support and so had either not sought any support or had not accessed any support beyond talking to friends or family about how they were feeling. When this topic was explored further, some affected others expressed the need for more specific support for people like them (that is, those impacted by gambling in addition to those who gamble), and some of these had accessed formal support for help with their mental health such as stress, anxiety or depression. Their main sources of support had been general medical services such as the GP or private counselling, but very few had contacted any specialist support services such as GambleAware about their own needs, as they were not aware that such support offerings extended to affected others.

Barriers to women accessing support for gambling harms

Phase 1 identified five consistent themes around the barriers to gambling treatment and support for women. These were: a belief that gambling is not harmful; stigma, shame and fear; low awareness and understanding of prevention and treatment service offerings; poor understanding among professionals and practical barriers such as costs. Phase 2 findings more strongly support the first three of these, with weaker evidence for the other two barriers.

The belief that gambling is not harmful continues to be a strong reason for women not accessing support at Phase 2. Women who do not make the connection between their gambling and harms, or recognise the severity of their gambling problem, are unlikely to want or seek treatment or support. Findings suggested that some women were in denial about the negative effects of their gambling, minimising the impact it had on them and their families.

Some women simultaneously claimed that their gambling was not harmful while describing gambling harms such as the arguments they had about it and the steps they took to hide both their behaviour and the consequences (for example, financial losses) from loved ones. This was not linked to PGSI score, with instances of women across the harm continuum unaware of whether they could benefit from support. This was less of a barrier for affected others who were often more easily able to see that the other person's gambling was causing harm.

Linked to this was the second barrier of stigma, shame and fear associated with accessing support. Phase 1 identified that even if women suspected or believed they might have a gambling problem, the shame of gambling and not wanting to burden loved ones could prevent them from talking to trusted friends or family. This also emerged as a strong barrier in Phase 2 and appeared to partly underpin women's denial that their own gambling was harmful, as their feelings of shame around gambling further motivated them to deny and downplay any problems. For affected others, the strength of this barrier varied.

Low awareness and understanding of prevention and treatment service offerings continues to be a strong barrier for affected others who were not aware that specialist support existed and would welcome finding out more. In contrast, women who gambled did not lack awareness that support, or treatment existed, however, only women who had accessed such support had any detailed understanding of what such services entailed, and therefore for whom the services were suitable. Those who had not sought any support had difficulty articulating what prevention and treatment services might entail beyond the basic, for example, "see the GP", "get counselling", and "go to Gamblers Anonymous". Some women assumed that support services would promote abstinence, which could act as a further barrier to any who did not wish to stop gambling.

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A further complication for women who gamble was that even those who recognised that their gambling was having a negative impact on them often questioned whether their own gambling harms were "serious enough" to warrant seeking support, or whether their gambling behaviour was sufficiently compulsive/problematic to be classed as something they needed support with. They therefore worried that a dedicated support service might judge or dismiss their need for support, that it was "not for people like them" and that they might be wasting the service's time and resources by asking for help. Women from Black communities occasionally felt that support services were 'not for black women'. – although there is only limited evidence from our Phase 2 sample, this view was underpinned by seeing adverts for gambling services that only featured white men.

Poor understanding among professionals was less likely to be discussed in Phase 2. This was partly because few women who took part had accessed formal support. Of those who had, most discussed their situation with their GP, and were satisfied with the level of help and support they had been given (even if this was only being signposted to Gamblers Anonymous) and only one woman said she felt poorly supported by a GP. However, other data sources show clear evidence that GPs have poor understanding of how to spot gambling harms in patients, how to talk to patients about these and about specialist gambling services. A forthcoming study IFF carried out for GambleAware[4] found that, of 150 GPs surveyed, only a quarter (25%) reported they were aware of gambling harm treatment and prevention services in their area, and as few as one-in-ten (10%) agreed they had sufficient information about services in their area.

Two-fifths (40%) of GPs felt able to recognise the signs of gambling harms among patients, 36% were confident about initiating conversations about gambling harms with patients, but only 26% agreed that they knew what questions to ask patients within these discussions.

Practical barriers to support, including costs such as for gambling blocker software, travel or childcare, were less commonly expressed in Phase 2. Women on low incomes, disabled women or women with mobility issues and those with caring responsibilities acknowledged some practical issues.

Enabling women to access support for gambling harms

Any future support offering will have to carefully consider how to enable women to recognise themselves as a potential service user. For women who gamble, any advertising will need to emphasise that support is for any woman who is unhappy with her gambling or would like to cut down, not just for those who "have a gambling problem". For affected others, it will have to first raise awareness that support is available, and also take steps to persuade them that their own situations warrant support.

Although women acknowledged that there was no 'one size fits all' approach, they were able to start to identify which factors might be important in an ideal support service.

- Women identified anonymity as important when they first reach out for support, particularly in raising their confidence and building trust with a support service, which in turn supports them being more open about their experiences and needs.

  This was particularly true for women who gamble, but also for some affected others experiencing shame or stigma, who were hiding a partner's gambling from friends and family. Other affected others could envisage themselves accessing group support, so for them, anonymity was less of a priority.

- Immediately available support was also seen as important for women who only worry about their gambling at specific times (for example, immediately following a loss) but later second-guess their own need for support. Having to make appointments and then keep them risks them opting out. This would also support women with busy lives, such as those who work or have caring responsibilities. It would also address a concern expressed by some affected others, who worried about long waiting times and having to answer multiple questions before being able to access support.

- Low commitment / low-pressure support could further help overcome confidence issues that might prevent women from making initial contact with support services. The majority of women described a preference for typing rather than having to speak (for example, a webchat), as this would allow them time to collect their thoughts, and to consider their words carefully. This would also provide another layer of anonymity for those who were least confident or most feeling pressure from shame and stigma. A service that was easy to opt out of (for example, a webchat) could also help to overcome confidence barriers and enable women to take a break if they felt overwhelmed. Women felt these steps were necessary to 'build trust' in a service provider before they could engage with more structured or longer-term support.

[4] Primary Care Gambling Service Evaluation: Final Report, May 2022. Prepared by IFF for GambleAware. Publication pending.

CONCLUSIONS

Phase 2 of this research has provided in-depth insight into the lived experiences of women who gamble, and women affected by others' gambling. Key learnings from this phase include:

- **Women in Great Britain experience gambling, and gambling harms, differently.** Factors which influence different experiences include **history of exposure** to gambling and **level of engagement** with gambling, **types and frequency** of gambling behaviours, **relationships** with others who gamble and **strength of social networks, life-stage parental responsibilities** and the experience of **health conditions**. Our research supports, and builds on, the themes discussed in the Phase 1's Rapid Evidence Assessment, such as heterogeneity and intersectionality, pathways and harm trajectories, and harm prevention and reduction approaches for women living in GB.

- **Positive childhood experiences and associations with gambling** were the most commonly described early experiences of gambling among the women we interviewed. These positive experiences were 1) **whole-family experiences** or 2) **bonding with a parent**. Women who gambled also tended to position gambling as a **normal activity**, with few downsides, at least initially. This framing typically persisted through to adulthood and provided the lens through which adult gambling was initially viewed as a normal, fun, harmless activity.

- Women who were affected by the gambling of others discussed experiences which differed in some ways from women who had experienced harm from their own gambling. For example, they were more likely to have **negative early memories** of gambling, with some having experienced **harms** from gambling of people close to them, from an early age.

- The main **barrier** to women experiencing gambling harms accessing treatment or support was women **not recognising that their experiences were harmful**. Gambling risks and harms tended to go unrecognised, or at least under recognised, by all women in the research and regardless of whether and the extent to which they experienced gambling harms. For example, **the belief that available support is not open to affected others**, is only for people with ' **serious addictions**,' for gamblers who want to **stop gambling entirely** or for people where gambling harm is their main issue to resolve. This pervasive view underpinned some women's belief they were **'unworthy' of gambling support**, as they did not consider the consequences they have experienced from their own gambling or the gambling of another to meet the 'threshold of need' required for support.

- The factors **triggering harmful gambling** differed from the factors motivating women to gamble. Protective factors that prevented or mitigated harm women experienced included **self-regulation techniques** adopted by affected others who also gamble, **social networks** like friends and family who provided a non-judgemental sounding board, and **engaging in activities** that helped counter periods of isolation and/or boredom.

- **There is no 'one size fits all' approach to treatment and support.** Yet, we identified six principles that underpin participants' responses to what good treatment and support for women experiencing gambling harms. This included **gambling language that resonates** with women (avoid term 'gambler'), **personalised support** (targeted at women from different socio-economic groups), **easy to access support** (low commitment, flexible, private/discreet), **free or free or affordable support, inclusive support** (gender and culturally appropriate; intersectional approach) and **non-judgemental support** (avoid abstentionist focus, reassure disclosing gamble harms will not lead to consequences).

We will test these principles during Phase 3 with women who have experienced harm, to understand how service providers may be able to put these principles into practice in new service delivery models or treatment and support options.

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