Problem Gamers' Perceptions and Experiences of Therapy

A Thematic Analysis

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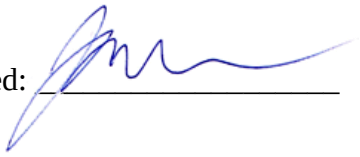
Contents

Table of Tables

Table of Figures

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), or material to which a substantial extent has been submitted for the award of any other degree or diploma of a university or other institute of higher learning.

Signed: 

James Driver 22/5/14

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I would also like to express my gratitude to my supervisor, Steve Appel, who has supported this research and to my colleagues who have given me support and feedback along the way – in particular, Mihili Salpitikorala and Jane Puckey.

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Abstract

This dissertation asks how treatment is experienced by problematic gamers and gaming addicts who have sought help for this issue. Four participants were interviewed using a semi-structured interviewing approach, and the transcripts of these interviews were analysed using the methodology of thematic analysis.

Two central themes were identified: 'Hope', and 'Fear'. These themes represented opposing forces which either motivated participants to engage with treatment and believe that positive outcomes were possible, or to avoid treatment and believe that negative outcomes were more likely. Each of these major themes was supported by two sub-themes which illustrated the major factors that contributed to a sense of hope or fear in treatment for this particular issue: 'Belief in self', 'Identification and belonging', 'Judgement', and 'Dismissal'.

'Belief in self' related to participants' trusting and valuing their own perceptions and experiences even when these were questioned or dismissed by clinicians. 'Identification and belonging' related to participants' feeling that there was a place for them in treatment, and finding others with whom they could identify in treatment. Both of these sub-themes contributed to participants' experiences of hope in the treatment.

'Judgement' related to participants' experiences of being pitied, condemned, or otherwise negatively evaluated by clinicians. 'Dismissal' related to participants' experiences of not being taken seriously, or being dismissed by clinicians. Both of these sub-themes contributed to participants' experiences of fear in the treatment.

Structure of Study

Chapter One provides an overview of the context in which the research occurs, including current literature, the personal experience of the researcher, and a definition of key concepts.

Chapter Two outlines the methodology and methods used in the research, including an overview of thematic analysis and semi-structured interviewing.

Chapter Three describes the process by which data was collected and analysed through the various stages of Braun and Clarke's (2006) approach to thematic analysis.

Chapter Four describes the results of this analysis, and explores the meaning and significance of the identified themes with extracts from the interview transcripts.

Chapter Five describes the possible implications of the findings in terms of clinical practice and the need for further research.

1. Background

1.1 Literature Review and Rationale

Although eighteen years have passed since the publication of the first study on internet addiction in 1996 (Young), the disorder as described by Dr. Young has still not been accepted as a distinct mental disorder in either the World Health Organisation's International Classification of Diseases (ICD-10), or the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM). However, a modified yet related condition labelled 'Internet Gaming Disorder' has been added to section III of the fifth edition of the DSM (DSM-V) indicating that it is a condition requiring further study, and a growing body of research is indicating that 'internet addiction' is too broad a term and that instead it may be more likely that individuals develop an addiction to activities that are facilitated *by* the internet rather than *to* the internet itself (Chou, 2001; Shorrock, 2012). Of these potential activities, one form of internet use that is most associated with addictive behaviour is the playing of online computer games, referred to as 'online gaming' (Young, 1998; Acie & Kern, 2011).

There is ongoing debate about whether internet addiction or online gaming addiction truly exist as disparate mental disorders that can be separated from other underlying issues such as depression and anxiety. Some authors suggest that there is insufficient evidence that video gaming can lead to impaired ability to control or limit gaming behaviours that would be sufficient to classify the behaviour as an addiction (Wood, 2007; Blaszczynski, 2008). Other researchers contest this, pointing to data which indicates that the idea that some people retreat into games as a coping strategy for underlying problems with depression or anxiety is "overly simplistic" (Gentile et al, 2011, p. 325) and that, "Although children do use games as a coping mechanism, it is not simply a symptom of other problems. Youths who became pathological gamers ended up with increased levels of depression, anxiety, and social phobia.

Conversely, those who stopped being pathological gamers ended up with lower levels of depression, anxiety, and social phobia." Others point to research which shows that, "On a neuronal and biochemical level, Internet gaming addiction appears to be similar to other substance-related addictions, thus supporting the assumption that it is an addiction, albeit a behavioural one, like gambling addiction" (Kuss & Griffiths, 2011, p. 290).

Due to the ongoing debate surrounding the validity of the terms 'internet addiction' and 'online gaming addiction', much of the research to date has focused on efforts to define and validate these terms and assess prevalence and aetiology (Porter et al, 2010; Griffiths, 2000; King et al, 2013; Ng & Wiemer-Hastings, 2005; Yellowlees & Marks, 2005) rather than exploring treatment methodologies or the experiences of those involved in treatment. Kuss and Griffiths touch on this in their review of research on gaming addiction, stating, "It appears that the current scientific knowledge of Internet gaming addiction can be categorized into aetiology, pathology, and associated ramifications" (2011, p. 289). At the same time, an increasing number of people are presenting to addiction and other mental health services who self-identify as having problems with online gaming (Acier & Kern, 2011). While it is clear that the debate about appropriate methods for defining and measuring online gaming addiction will continue for some time, I agree with the position stated by King, Delfabbro and Griffiths (2010) that, "The distinction between problem video game playing as a primary vs. secondary disorder is irrelevant from a clinical perspective" (p. 262) and that, "Preliminary research and theory may guide the development of therapy techniques for excessive and/or problem video game players".

While much of the research surrounding online gaming addiction has focused on diagnosis and aetiology, a number of studies have investigated different methods of working clinically with the issue. Amongst these was a review of treatment for internet addiction which

included several studies focusing on gaming addiction (King et al, 2011). Suggested and reviewed treatments for gaming addiction have included cognitive behavioural therapy (King, Delfabbro, & Griffiths, 2010), combined cognitive behavioural therapy and motivational interviewing (Rooij et al, 2010), pharmacological interventions (Han, Hwang, & Renshaw, 2010), treatment provided in a hospital setting (Beranuy, Carbonell, & Griffiths, 2013), and treatment provided through addiction treatment centres (Acier & Kern, 2011). However, despite this growing body of research, very little has been done to understand the subjective experiences of online gaming addicts *of the treatment itself*. Instead, research has tended to focus on gamers' experience of their gaming (Beranuy, Carbonell, & Griffiths, 2013), or on treatment outcomes as measured using clinical assessment tools. Because agreement and understanding of problematic online gaming is still in its infancy, it seems more important than ever that researchers and clinicians bear in mind Casement's exhortation to "learn from the patient" (1985).

It is therefore the aim of this dissertation to add to the clinical understanding of treating online gaming addiction by answering the following research question: What have been the experiences of treatment for gamers who have sought help for addictive or problematic gaming? A similar thematic analysis has been conducted into the experience of therapists working with internet addiction (Rooij et al, 2010), so this dissertation will also complement that research by presenting the other half of the picture, the client's experience.

The method for approaching this research is thematic analysis, which involves the coding and analysis of a data set in order to identify underlying themes. The data to be analysed was collected via semi-structured interviews which were conducted either face to face or via internet telephony.

1.2 Personal Experience

As this research is located within a qualitative and interpretative framework, the validity of the research is based on the transparency of research methods and an awareness of the researcher's subjectivity.

My interest in this research is influenced by my own experiences of gaming addiction. Between the ages of 17 and 21 I was gaming addictively, spending up to sixteen hours per day online in one of a number of massively multiplayer online roleplaying games. I was very aware that at the time there was no specialist help available for this problem, and indeed I did not recognise it as the primary problem despite its significant destructive impact on other areas of my life. I was receiving psychiatric care and psychotherapy for depression at this time, and while this was partially successful in treating both my depression and my gaming addiction, in hindsight I believe that therapeutic interventions more specifically targeted at the gaming would have been beneficial. However, at least in part because of the shame I felt about my gaming I never discussed this in any detail with my therapist, and so a situation was co-created in which my gaming was largely ignored throughout the treatment. As a consequence, I largely overcame my own addiction through individual efforts combined with therapy that was not specifically targeted at the problem I was experiencing.

About a decade after this period of addictive gaming I trained as a psychotherapist, and my first placement was in a residential drug and alcohol treatment programme where I became aware of many of the behaviours and psychological processes associated with addiction. I became interested in the experiences of others who had had problems with gaming, and began reading first-hand accounts of other gaming addicts online. This revealed that many others had been through similar experiences to myself and had similar difficulty in finding appropriate treatment. It was also clear from this research that there was a greater awareness

of potential psychological problems arising from gaming than there had been ten years ago. However, what was apparent in the material that was available was that although research had explored the experiences of gaming addicts generally, very little research existed exploring their experiences of treatment, and I developed a strong interest in contributing to this overlooked topic.

Due to my own experiences of gaming addiction not being understood or addressed directly in my own life, it is possible that I have over-emphasised similar experiences shared by the research participants. However, I believe that the rigorous approach used in the analysis and the data that has come from the interviews speaks for itself, and reveals that gaming addicts are still experiencing a lack of understanding, are being dismissed by professionals, and that there are still few professionals who feel comfortable and competent in addressing this problem.

1.3 Definition of Key Concepts

Due to the lack of consensus around some of the terms used in this research, it is important that they be clarified as this has impacted on the analysis process in terms of the codes and themes selected. In particular, the terms 'gaming addiction' and 'clinician' are used extensively throughout this research and are therefore defined below. In addition, as the research question focuses on the experiences of treatment, I have also defined what is meant by 'experience' in this particular context.

***Gaming Addiction**:* As noted previously, there is no clear consensus as to what exactly constitutes online gaming addiction or if this is the best term to use to describe the phenomenon (King et al, 2013). Various phrases including 'Problematic Video Gaming',

'Internet Gaming Addiction', 'Pathological Computer Gaming' and others have been used by different authors.

I initially used the phrase 'problematic gamng' for this dissertation due to the ongoing debate surrounding the validity of the term 'addiction' in this context. However, since the focus of this research is on the subjective experience of those who see themselves as suffering from problems arising from their gaming, in the end I settled on a term that reflected the phrases most commonly used in their own narratives. Three out of the four participants used the term 'addiction' extensively to refer to their excessive gaming, and three out of the four participants used the word 'gaming' to describe their behaviours. None of the participants used the phrase 'video gaming' or 'computer gaming' with any regularity. For this reason, I have used the phrase 'gaming addiction' throughout this research to refer to the phenomenon under investigation.

I consider 'gaming addiction' to be defined by the criteria suggested by Griffiths (2008). That is, an individual's gaming can be operationally defined as an addiction when it meets the following criteria:

Salience- Gaming becomes the most significant activity in the person's life and dominates their subjective experience in terms of pre-occupation, cravings, and a deterioration in the quality of other areas of their life such as relationships and social interactions.

Mood modification – Gaming creates a modified emotional state for gamers, which may be experienced as a 'high' of sorts, or more commonly may be experienced as a decrease in negative mood states when the gaming is used as an 'escape'.

Tolerance – Increased periods of gaming or more intense gaming experiences become required by the gamer in order to achieve the mood modification effects described above.

Withdrawal Symptoms – Gamers experience negative thoughts or feelings when not gaming, including reduced emotional regulation and irritability.

Conflict – Gaming begins to create conflict between the gamer and others in their interpersonal world such as with family members or friends, or within their intra-psychic world in terms of feelings of shame, guilt or regret about their gaming behaviours.

Relapse – Gamers may make repeated attempts to reduce or abstain from gaming, but find themselves unable to sustain this and quickly return to previously high levels of gaming.

An alternative view of addiction which also supports the use of the term for this research is that proposed by Dodes (2003). Dodes states that addiction is not dependent on an external substance or activity, but is an internal psychological process employed in response to a feeling of being powerless and overwhelmed. He describes the addictive act as a compromise, a way of re-asserting control over a situation in which a person feels powerless or incapable of acting in a more direct way. He suggests that diagnosis of addiction should be approached by assessing the psychological significance of the addictive act to a person, such as whether it is being used when the person feels bad about themselves, to substitute for a relationship, to solve emotional problems, or to create a sense of doing *something* to address a problem. From this perspective, I believe the term addiction accurately describes participants' self-reports of the ways in which gaming was used in their lives.

Clinician: It became apparent early in the interviewing process that many of the participants were unfamiliar with the exact training and specialisations of the mental health professionals who had treated them. For this reason, the inclusive term 'clinician' is used throughout this research to refer to those mental health professionals who were involved in providing treatment for gaming addiction. From participant's statements, it is likely that these

clinicians included social workers, psychologists, alcohol and drug counsellors and peer support workers.

Experience: In researching the experiences of gamers who have received treatment, I was interested in understanding both their interpersonal *and* intra-psychic experiences. That is, I am considering experiences of treatment to include both descriptions of external experience such as what clinicians said and how they responded to participants, and internal processes such as participants' feelings, thoughts, imaginings and expectations about treatment.

2. Methodology and Methods

2.1 Introduction

This chapter introduces the methodology used in this research, divided into a discussion of the broader epistemological framework for the research followed by a discussion of the rationale for the specific methodologies chosen. The research is fundamentally qualitative in nature, meaning that it acknowledges the subjectivity of both researcher and researched and emphasises that knowledge and expertise are held by those with first-hand experience of a phenomenon. The research also fits within an interpretative and phenomenological framework, meaning that knowledge is seen to be dependent on subjective experience and constructed within a particular cultural context and time.

Data for the research was collected via semi-structured interviews, a form of interviewing which is designed to explore the subjective experience of research participants and the meanings they assign to these experiences (Adams, 2010).

The data collected from these interviews was then transcribed and analysed using a thematic analysis approach. Thematic analysis is a methodology that relies on rigorous coding of data to identify patterns in the data. These patterns become encoded as themes which describe the data in rich detail, often providing insights and interpretations of the data that would not be possible with a more cursory analysis (Braun & Clarke, 2006).

A discussion of how these methods were applied to this particular study follows in chapter 3.

2.2 Methodology - Qualitative Research

The overall aim of research is to develop a deeper understanding of a topic or issue that is not based solely on the persistence of a viewpoint, on intuition, or on authority (Grbich, 2013). It aims to do this by constructing a question and study that elicit evidence about the topic that can then be interpreted in order to reach conclusions based on the evidence at hand.

Quantitative research approaches this aim by measuring observable factors that can then be compared in a statistical way, whereas qualitative research acknowledges both the inevitability and the value of subjective experience and manages uncertainty and bias "by using the most transparent approaches available" (Grbich, 2013, p. 4).

The underlying philosophy of qualitative research emphasises a number of key criteria (Grbich, 2013):

- Subjectivity is seen as having value, and research is designed in such a way that the subjectivity of both the researcher and the researched are incorporated into the data
- Validity is focused on transparency and getting close to the subject under investigation, reliability is seen as being based on quality research design, and

generalisability is seen as being more localised and specific to the time and place in which the research occurred

- Those being researched are seen as being experts and having knowledge and wisdom about their own experience, rather than the researcher being seen as expert
- Context is seen as crucial, and cultural and environmental factors are seen as influencing the subjectivity of the researched

Qualitative research is typically seen as most appropriate for investigations into culture, behaviours, and phenomena. What it lacks in generalisability it makes up for by providing a much deeper and richer investigation into the significance and meaning that people make of the experiences that constitute their lives.

2.3 Methodology - Interpretative and Phenomenological Research

Interpretative methodologies are ones which "assume that there is no objective knowledge independent of thinking" (Grbich, 2013, p. 7). This assumption suggests that the same events are experienced differently by different people, and that both individual and shared meanings of phenomena are constructed through the use of signs, symbols and traditions that are accepted by members of a culture.

When applied to research, this philosophy holds that the researcher's ability to interpret and make meaning of another person's experience is limited by the researcher's own subjectivity and life experiences, and that any understanding of a phenomenon under investigation is jointly constructed through the interaction between the researcher and the researched. Research within this paradigm is often focused on understanding the ways in which people

make sense of their experiences, and how their broader social and cultural environment and history may impact on this understanding.

Phenomenological methodologies share many similarities with interpretative approaches. These methodologies are also concerned with understanding the meaning that people make of their lived experience, and there is a particular emphasis on the transitory nature of human experience. Seidman states that this shifts the focus of phenomenological research onto "ask(ing) participants to search again for the essence of their lived experience, the real 'is'" (2013, p. 17). He suggests that since moment to moment experience is fleeting, research of this nature aims to uncover the unchanging 'essence' of an experience that remains absolute despite the transitory nature of subjective experience.

Phenomenological methodologies stress the importance of subjective experience, while simultaneously highlighting the impossibility of ever truly being able to understand a phenomenon from another's perspective. Research focuses on the moment-by-moment lived experience of individuals to make sense of phenomena. This constant, overlapping flow of thoughts, feelings, sensations and expressions all constitute lived experience and contribute to the meaning that individuals make of their lives and the phenomena they experience. Phenomenological research aims to try and describe and understand these experiences, but recognises limitations in doing so; the transitory nature of experience means that by the time it is described it is already in the past, and experiences are communicated via language which is imperfect in its capacity to communicate meaning (Seidman, 2013).

2.4 Methods - Semi-Structured Interviewing

Interviews have long been one of the most important data collection methods in qualitative research due to their ability to provide understanding of complex social and psychological issues. More broadly, telling stories and recounting narratives of experience has been the main way in which humans have made sense of their experience throughout recorded history (Seidman, 2013).

Interviewing is a formalised way of recording narratives, a process of "selecting constitutive details of experience, reflecting on them, giving them order, and thereby making sense of them" (Seidman, 2013, p. 7).

The form of interviewing used in this research was semi-structured interviewing, which fits within the broader paradigms of phenomenological and interpretative methodologies.

Semi-structured interviews are recognised as being a particularly effective method of data collection "where little is known about the topic of interest – where the topic of interest may be particularly sensitive, such as supporting vulnerable parents or postnatal depression, and where the variability rather than the commonality of responses is the focus" (Adams, 2010, p. 18).

Very little is known about gaming addiction treatment, and given the newness of the topic area and the significance of shame and stigma in treating other addictions (Potter-Efron, 1989; Wilson, 2000; Milliken & Strickler, 2004) it seems likely that gaming addicts could experience the topic as sensitive and difficult to talk about. This was later confirmed in the results from these interviews. Additionally, since gaming addiction treatment is in no way standardised at this time, I expected that there might be no commonality of response between participants, and so it was crucial to explore this variability.

For all these reasons, and since the data analysis method selected was formulated for the purpose of analysing interview data, it was appropriate that semi-structured interviewing be used to collect data for this research project.

Although semi-structured interviews are a process for eliciting and recording a personal narrative and have many features in common with a simple conversation, there are a number of significant differences between interviewing and conversation and a number of considerations that the interviewer must reflect on before the interview.

This begins with preparation for the interview, which includes practical, ethical and contextual considerations (Adams, 2010). The interviewer must consider the space that will be used for interviewing, the duration of the interview, issues of privacy and confidentiality, how notes will be recorded, how discussion of sensitive topics will be managed, the nature of questions that will be asked, and their own biases and assumptions about the topic.

During the interview itself, different skills come into play, perhaps the most important one being listening. The importance of this is clear from Seidman's (2013) structuring of his book on interviewing in which two sections begin with the phrase "Listen More, Talk Less" and a third emphasises the importance of being able to "Tolerate Silence". This is reiterated as a "golden rule" of interviewing in Adams (2010).

The interviewer must engage in 'active listening' and resist the temptation to interrupt or ask clarifying questions during the narrative. In addition, listening involves more than just an awareness of content – the interviewer must remain alert to unspoken meaning in the form of body language, facial expressions, tone of voice, as well as broader contextual issues such as timing and the wellbeing of the interviewee (Adams, 2010).

The interviewer initiates the interview by asking a series of questions based on the topic under consideration. Some of these questions may have been prepared in advance, but the interviewer must remain flexible and allow the participant to guide the interview (Adams, 2010) as well as taking note of points that might require further investigation so as to return to them later (Seidman, 2013). The interviewer aims to ask open-ended questions that do not lead the participant towards any particular response. For example, the interviewer might be more likely to ask the open-ended question 'Tell me about how your gaming affected the rest of your life?' than a closed question such as 'Did your gaming become a problem for you in the rest of your life?'

Throughout the interview, the interviewer must be aware of their own expectations and assumptions in relation to the topic area, and strive to maintain an open and non-judgemental attitude towards the answers and narratives provided by the interviewee (Adams, 2010). If the interviewer is truly able to listen without judgement, they will be better able to facilitate a meaningful interview and ensure that the interview becomes a "conversation where the outcome is a coproduction of the interviewer and the subject" (Kvale, 2008, p. xvii).

2.5 Methods - Thematic Analysis

Thematic analysis is also generally considered to be part of a broader tradition of interpretative methodologies within qualitative analysis, and like many other qualitative approaches seeks to "arrive at an understanding of a particular phenomenon from the perspective of those experiencing it" (Vaismoradi, Turunen, & Bondas, 2013, p. 398). This is achieved by analysing the data and identifying recurring patterns within it which are then

abstracted into themes. These themes often provide rich information about core meanings and concepts expressed within the data.

Thematic analysis is often considered to be a core skill of qualitative analysis (Braun & Clarke, 2006), and is sometimes described less as a specific method than as a tool which can be used *within* other analytic methodologies (Boyatzis, 1998). However, some authors do see it as a distinct methodology belonging to a particular tradition. For example, Grbich (2013) sees thematic analysis as belonging to the tradition of critical ethnographic approaches, while Holloway and Todres (2005) see it as being one part of phenomenology.

Thematic analysis is also often seen as overlapping significantly with other more specific forms of "branded" qualitative analysis such as grounded theory or narrative analysis (Vaismoradi, Turunen, & Bondas, 2013), and so despite being described as a crucial tool for qualitative analysis, thematic analysis as a methodology is often seen to be poorly-defined (Braun & Clarke, 2006). Grbich (2013) suggests that one of the reasons for this is that thematic analysis is "particularly idiosyncratic" since it involves a subjective process of assigning codes based on knowledge of the literature, evidence from the area being studied, personal knowledge or the knowledge of participants (p. 61). However, she also emphasises that despite this idiosyncrasy, this analysis method requires that "the data should speak for itself initially before researcher-designed labels are over-imposed".

Thematic analysis as an approach has also been praised for its flexibility, though at the same time there is a risk that the approach could lack internal consistency and coherence if not applied in a systematic manner (Vaismoradi, Turunen, & Bondas, 2013). For this reason, Braun and Clarke (2006) among others have attempted to define a more clearly demarcated approach to conducting a thematic analysis, and this research project is largely based on the methods outlined by these authors.

My aim in conducting this analysis was to develop a deeper understanding of participants' experiences beyond a purely literal interpretation, and a thematic analysis is ideally suited to this purpose as it requires this in-depth examination of the data. Further, because a thematic analysis involves line-by-line segmentation of the data (Grbich, 2013), it is possible to reduce the impact of researcher bias and let the data speak for itself. This is particularly valuable given that I have relevant personal experiences of the topic under analysis which will likely have impacted my reading of the data.

Thematic analysis is also a suitable method for developing an in-depth analysis of smaller data sets, and so fits appropriately with the scope of this dissertation as a project undertaken by a single researcher.

Lastly, a thematic analysis approach is appropriate for this research due to its philosophical underpinnings within interpretative and phenomenological traditions. Interpretative and phenomenological approaches place an individual's subjective experience at the heart of the research, and since clients' subjective experience is a significant factor in predicting positive treatment outcomes in therapy (Pesale, Hilsenroth, & Owen, 2012; Gonzalez, 2001) it is crucial that researchers and clinicians understand the treatment experiences of gaming addicts if we are to develop effective treatment.

2.6 Methods – Phases of Thematic Analysis

The method for a thematic analysis involves a number of sequential steps, beginning from and overlapping with data collection. Braun and Clarke (2006) divide the process into 6 phases:

1. Familiarizing yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

These steps are very similar to those proposed by Grbich (2013) in her discussion of thematic analysis. However, as will be discussed most of these phases involve multiple steps depending on the results that are generated.

Phase 1 – Familiarizing yourself with the data

Braun and Clarke (2006) state that, "It is vital that you immerse yourself in the data to the extent that you are familiar with the depth and breadth of the content" (p. 87). In the case of interviews, they suggest that part of this process involves the transcription of the interviews themselves, including at a minimum a verbatim account of all verbal (and some non-verbal) communications.

Phase 2 – Generating initial codes

In this phase, initial codes are generated from the transcripts by analysing the text line-by-line and generating words or short phrases that capture the essential meaning of each part of the

text. Braun and Clarke (2006) emphasise the importance of giving equal attention to all parts of the data, and differentiate between coding which may be more "data driven" and coding which may be more "theory driven" (p. 88). They describe data-driven coding as being coding which is primarily dependent on the data itself, whereas theory-driven coding may be guided by specific questions that the researcher has in mind when coding the data.

Phase 3 – Searching for themes

Phase 3 can begin once all data has been coded. The researcher now begins to group codes identified in the data into possible themes. This can be done in a variety of ways such as through the use of visual thematic maps (Braun & Clarke, 2006) or through the use of tables (Grbich, 2013). Codes are grouped on the basis of apparent connections in meaning, and the researcher will create names for each emerging theme which seem to capture the essential similarities between the grouped codes. Braun and Clarke point out that multiple levels of themes may be created at this point, and so in essence this phase may involve multiple iterations of creating sub-themes which are then grouped into over-arching themes. These themes are then further reviewed during the next phase.

Phase 4 – Reviewing themes

In this phase, the themes are reviewed and checked for validity in terms of consistency and themes may be consolidated, renamed or dropped altogether. The reasons for this are numerous – it may be that there is insufficient data to support some themes, some themes may appear to share sufficient similarities that they can be better categorised under a single heading, or themes may be overly broad and require further refinement. Braun and Clarke point to the importance of ensuring that themes of sufficient levels of "*internal homogeneity* and *external heterogeneity"* (Braun & Clarke, 2006) which they define as meaning that all

codes within a theme should cohere meaningfully, and themes should be sufficiently different from each other as to justify their separation.

Phase 5 – Defining and naming themes

Phase 5 continues from phase 4, and involves further refinement of the themes in terms of identifying them with appropriate names and definitions. In this phase, existing themes are analysed in order to identify the 'essence' of the theme, and a description and title for the theme generated to capture the essential meaning of the codes that have contributed to this theme. At this stage, the researcher writes a detailed analysis of the theme which explains how the theme came to be, the meaning it has in relation to the original data, and a description of any sub-themes that are critical to understanding the theme.

Phase 6 – Producing the report

In the final phase, the researcher creates a report based on the analysis of the data. In this write-up, the researcher includes the analysis created in step 5 above, and also outlines the methodologies and methods used in arriving at the themes identified. At this point, the researcher may also return to the original data and include excerpts in order to illustrate the themes selected, although as Braun and Clarke (2006) note, the write-up "need(s) to do *more* than just provide data. Extracts need to be embedded within an analytic narrative that compellingly illustrates the story you are telling about your data" (p. 93). A full description of how each phase of this process was executed is outlined in the following chapter.

3. Data Collection and Analysis

3.1 Introduction

This chapter describes how the study was conducted, from the initial recruitment of participants through to the final analysis of the data. Four participants, two male and two female, were interviewed. Two of the participants were in New Zealand, one was in the United Kingdom and one in Poland. Participants ranged in age from 22 to 36. Participants were interviewed using a semi-structured interviewing format, and the interviews were then transcribed, coded and analysed as per Braun and Clarke's (2006) six phases of thematic analysis to create a series of initial codes, basic themes, sub themes, and finally global themes. Following the identification of global themes, the sub-themes were revisited and regrouped resulting in two global themes and four sub-themes.

3.2 Participant Selection and Interviewing

The first step of the data collection process was to make contact with and select participants. The initial intention of this research was to select participants exclusively from within New Zealand. Recruitment of participants was approached by distributing hard-copy A4 posters, and by making posts on online forums. Both the fliers and the online postings provided a brief description of the aims of the research and the criteria for taking part, and invited those who might be interested to contact the researcher. Ethics approval was sought and granted by AUTEC for the recruitment posters, participant information sheets and consent forms used. Copies of these forms are included as appendices.

These recruitment postings named two key criteria for being eligible for the study; that participants identified as having had problems arising from their online gaming such as

neglecting other areas of their life, and that participants had discussed these problems with a mental health professional of some kind. Permission was obtained and hard-copy fliers were posted at the following universities within New Zealand: Canterbury University, CPIT (Christchurch), AUT (Auckland), University of Auckland, and Wintec (Hamilton). In conjunction with this, online postings were made on the forums at nzgamer.com, gameplanet.co.nz, and nzgames.com.

As a result of these postings, a number of enquiries were received from possible participants. However, all but one of these were ineligible for the research as while they met the criteria for having problems arising from their gaming, only one of them had discussed these problems with a mental health professional. Of those who did make contact, there was a clear interest in the aims of the research, and a number of individuals both through private communication and through the online forums where the recruitment information was posted commented that they believed there was a need for a greater understanding of treatment options for gaming addiction.

When it became apparent that it would not be possible to find sufficient participants within New Zealand, the research proposal was modified to include international recruitment, and further approval was sought and granted by AUTEC for this change. Similar recruitment messages were then posted on online forums at olganon.org and reddit.com/r/stopgaming, both of which are online communities for those attempting to overcome gaming addiction. Again, many of the respondents who identified as having online gaming problems had not discussed these with a mental health professional, but in the end four participants were selected from those who had responded. Two of the participants were male and two female, with ages ranging from 22 to 36. Two of the participants were living in New Zealand, one in the United Kingdom and one in Poland, although two of the participants had also emigrated

to their current countries. All participants spoke English fluently, though it was not the first language for two of them.

Participants had received a range of treatments and engaged with mental health professionals in a variety of ways. One participant had received residential in-patient treatment for gaming addiction and had been heavily involved in 12-step meetings, one participant had received brief assessment and counselling through her GP and a counselling service following a major natural disaster, one participant had received counselling from a range of different professionals over a number of years including social workers and counsellors, and one participant had received counselling and been involved with psycho-educational groups primarily as treatment for depression and anxiety.

While this small participant pool and diversity of participant experiences would prove problematic in a quantitative study, this is not the case for a qualitative study of this nature. As Seidman (2013) points out, there are no hypotheses being tested and so the issue of whether the findings are generalisable to a wider population is of little significance. Instead, the goal of the researcher is to present "the experience of the people he or she interviews in compelling enough detail and in sufficient depth that those who read the study can connect to that experience, learn how it is constituted, and deepen their understanding of the issues it reflects" (p.54).

Initial contact with participants was primarily made via email. Seidman (2013) states that, "Building the interviewing relationship begins the moment the potential participant hears of the study" (p.50) and emphasises the importance of the researcher making contact in person where possible. In keeping with Seidman's recommendations, it was my original intention to meet with the participants in person before conducting the interviews in order to establish a relationship and orient them to the interviewing process. However, as it was not possible to

recruit interviewees locally it was impractical to do this and so instead this process was primarily conducted via email. Interviewees were provided more detail about the nature of the study, and were asked to sign a consent form confirming their willingness to participate. They were also advised that the interview would take around 90 minutes and that they would be reimbursed for costs incurred by participating.

All of the participants who had responded at this point agreed to be interviewed, and arrangements were made to conduct these interviews. The two interviews with participants outside of New Zealand were conducted via internet telephony, and the two interviews in New Zealand were conducted in person. I prepared for these interviews by considering my own preconceptions and biases relating to the topic, considering the format of the interview and how it would be recorded, and preparing a selection of sample questions that could guide the exploration of the topics under consideration.

I made the decision to record in-person interviews using a digital voice-recorder, and online interviews using the open source audio-editing software 'Audacity'. A number of sample questions were prepared. In keeping with common recommendations for semi-structured interviewing (Adams, 2010), these were designed to be open questions that would invite further discussion and exploration of a topic. The following is a sample of some of the questions prepared:

1. Can you tell me about the time when you first felt that gaming might be a problem for you?
2. Can you tell me about how you ended up seeing your counsellor/therapist for the first time?
3. Can you describe the first time you brought up the issue of gaming with your counsellor/therapist?

4. Can you describe what you thought about and how you felt before bringing the topic up with your counsellor/therapist?

Adams (2010) stresses the importance of providing space to enable the participant to guide the interview, and so during the interview itself I used these questions as a guide but did not attempt to adhere rigidly to them. In addition to using these questions as a guide, I used my own judgement and responses to the participants to facilitate the exploration of topics that seemed to be of particular emotional significance to the participant, or topics that I felt were particularly pertinent to the research question. Throughout the interviews, I also noted occasions where participants hesitated in their responses, or seemed uncertain about the responses they gave and used this to prompt further exploratory questions.

Following the interviews, the recordings were transcribed using 'Listen N Write Free', a freeware transcription software package. These transcripts were then reformatted to improve legibility in preparation for the following stages of interpretation and coding, and saved as Microsoft Word documents.

This process of carrying out, recording and transcribing these interviews aligns with Braun and Clarke's phase one of thematic analysis and provided an opportunity for me to familiarise myself with the data. The transcription of the interviews was a long and involved process, and due to the speed of speech of both participants and myself often required listening to the same section of interview four or five times before an accurate transcription could be recorded. As a result, I became intimately familiar with the content of the interviews by the time transcription was complete, which greatly aided the later stages of analysis as I was quickly able to identify the origins of statements or codes and find them within the context of the original interviews.

3.3 'Close-To-Text' Coding

The first stage in the analysis process once the interviews were transcribed was to generate initial codes, which aligns with Braun and Clarke's (2006) phase 2 of thematic analysis. Braun and Clarke emphasise the importance of being systematic during coding to ensure that the entire data set is given equal attention. Grbich (2013) makes a similar point, and suggests that one way to approach this is to segment the data on a word-by-word, line-by-line basis. I was initially overwhelmed by the size of this task, and so in my initial attempts at coding I tried to minimise the number of codes by selecting codes that were broad enough to be inclusive. However, on reflection it became apparent that I was applying a large degree of subjectivity in my interpretation of the data, and I became aware that certain codes could easily have been interpreted in a different way which would have remained just as true to the original participant statements. Consequently, I rejected these initial codes that I had created and began the process again, this time generating codes in a way that were designed to be as 'close-to-text' as possible and which minimised my own subjectivity. However, it must be acknowledged that even during this 'close-to-text' coding there is an inherent element of subjectivity in terms of which items I coded and which words made the focus of any particular code. In keeping with Braun and Clarke's (2006) advice, I therefore aimed to code the data inclusively, i.e. by allowing multiple codes to be applied to the same data item, and including some of the surrounding data when coding to provide context.

This coding process was done using a number of columns in Microsoft Excel. This enabled me to practically and easily manipulate and group codes in the later stages of analysis.

I arranged the data by creating a separate sheet for each interview. In the left-most column of each sheet, I placed the transcript from each interview, with each of the cells alternating between what I had said, and how the interviewees had responded. In the right-hand column,

I recorded the codes I generated that related to the corresponding segment of the interview. By highlighting both the interview transcript and the codes in two different colours, I could easily keep track of which codes related to which statements taken from the transcript, as shown in Table 1.

Table 1

Example of Transcript and Close-to-Text Codes

Transcript	Codes
Yeah, there... there's... I I mean I gamed the... entirety of my adolescence (mmhmm) and... the... the majority of my childhood (yep). But the beautiful thing is... that's sort of come up as a result, I'm now in recovery at the age of 22 (mmhmm) which is extremely young to... to be in recovery, and it's... such a gift and there are so many beautiful things (yes) but I never noticed them, I was gaming, and it's... it's like being reborn, and I'm so glad... that... I went to... to Lifeworks and I think the... one of the most profound things I found is that addicts... addicts are all the same, we are, we're all the same, it's all the same disease, (mm) and we just... just self-medicate it in different ways. My way was... was excessive game playing, and... other people's experiencing... other people it's drugs... but the cure is the same, it's... it's... y'know, just the 12 steps (mmhmm, yep) and, and I've no idea how it works, but it... it does	I gamed the entirety of my adolescence I gamed the majority of my childhood It's beautiful to be in recovery at the age of 22 it's a gift to be in recovery at a young age there are so many beautiful things I never noticed while gaming being in recovery is like being reborn I'm glad that I went to treatment I found that addiction is the same disease I found that addicts are all the same it was profound to me to find that addicts are all the same I found that addicts just self-medicate in different ways I self medicated my addiction by excessive game playing 12 steps are the same cure for all addictions I don't know how the 12 steps work but they do

This example illustrates how codes were generated which captured the basic meaning of each participant statement, and how context was included at times to ensure that codes could be readily interpreted during the following steps of the analysis process. For example, the statement "My way was... was excessive game playing" was coded as 'I self medicated my addiction by excessive game playing' by drawing on the surrounding context. In doing so, a code was generated which carried more of the intended meaning of the statement.

This process was repeated across all four interviews, creating a total of 1629 unique codes. During this process, the majority of the data was coded although small sections of the transcripts were not coded if they were judged not to be relevant to the research question. However, in order not to presuppose relevancy at this stage of the analysis, any statements relating to gaming, addiction, treatment, recovery, or personal experience were recorded. As an example of data that was not coded, in the above table the words, "Other people's experiencing... other people it's drugs" were not coded. This phrase was deemed not to be directly relevant to the research question, and that aspects of this statement that *were* relevant to the research question were already captured by the codes 'I found that addicts just self-medicate in different ways' and 'I found that addicts are all the same'. The phrase that was not coded focused on the form that this self-medication would take for other addicts, and was therefore not deemed of significance to the research question.

3.4 Creating Basic Themes

Once the initial 'close-to-text' codes were generated, these codes were analysed and initial patterns and overlap between codes were identified. Patterns between codes were used to sort the codes into "basic themes" (Attride-Stirling, 2001, p. 392), which were typically short

phrases reflecting the fundamental nature of the included codes. This aligns with the first step of Braun and Clarke's phase 3 of thematic analysis. At this stage of analysis, codes were grouped into themes solely on the basis of content, and not on interpretations made on theoretical grounds. In order to minimise the impact of researcher bias, I made the decision to limit the amount of theoretical interpretation of the codes until a smaller number of themes had been created that were directly related to the content of the transcripts.

Both Braun and Clarke (2006) and Attride-Stirling (2001) describe identifying themes as an essentially iterative process, in which codes are analysed and re-analysed to create a network of themes within a hierarchical structure. Although the language that these authors use is different, the principles are the same, with the end goal of thematic analysis being the identification of a small number of global themes, each of which contains a number of sub-themes, each of which contains a number of basic themes, each of which contains a number of codes. This hierarchical organisation of codes, basic themes, sub-themes and global themes is illustrated in Figure 1.

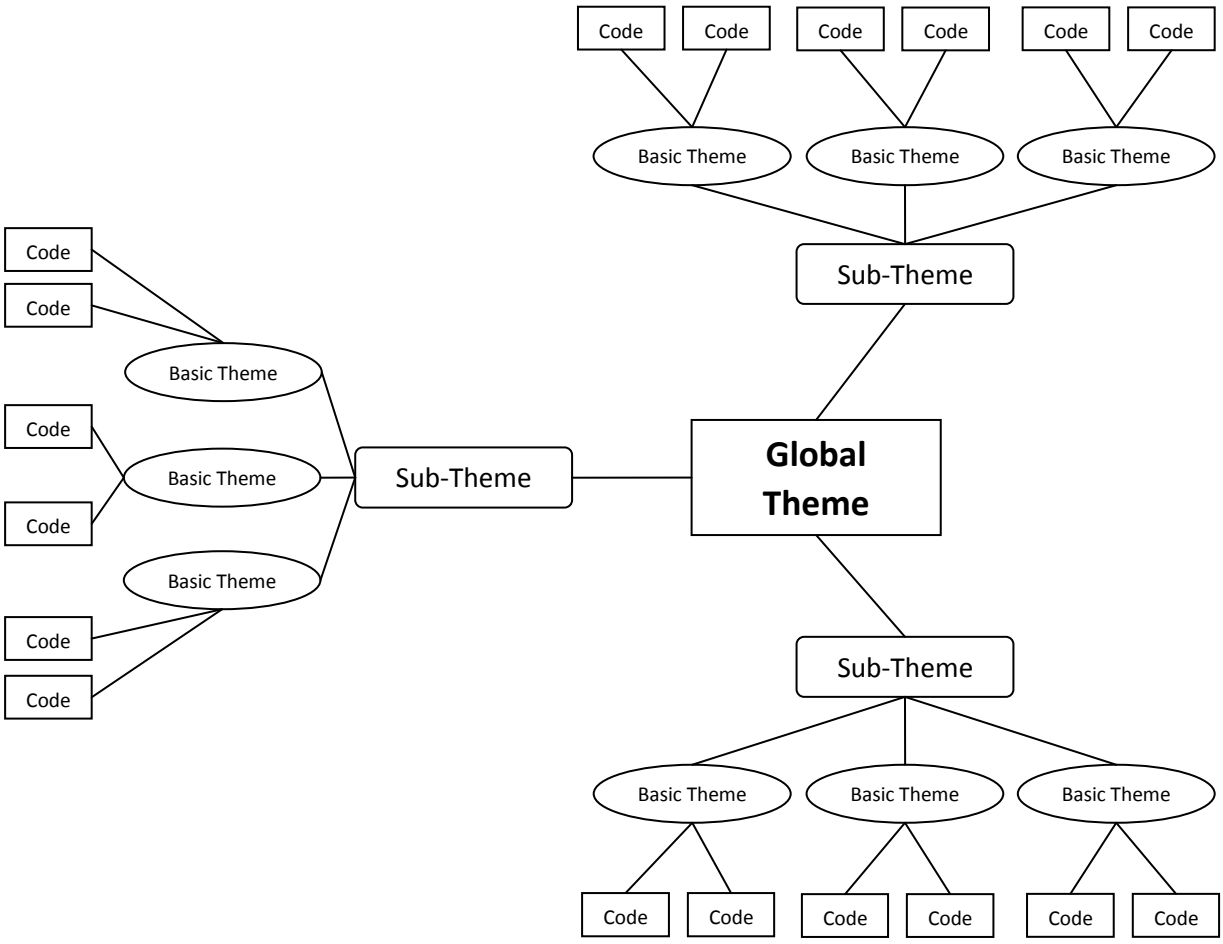

Figure 1. *Network of themes.*

Through this process, the initial 1629 unique codes were reduced to a total of 576 basic themes. Many of these basic themes were very similar and were later consolidated into single sub-themes. For example, three basic themes were identified that related to professionals dismissing, not treating, or not exploring gaming addiction. Although these could have been further consolidated at this stage, I decided to leave them as separate basic themes since there were subtle distinctions between them. That is, I saw that dismissing gaming addiction was a subtly different process to not treating gaming addiction. In doing this my aim was to concentrate the impact of my subjectivity and interpretation of the data on the later stages of

analysis, and minimise its impact on the earlier stages where I attempted to remain as close to the data as was reasonably possible.

Again, I conducted this next stage of analysis using Microsoft Excel. I began by sorting the previously generated codes into alphabetical order, and recorded one code per line within a new spreadsheet. I then analysed each code one at a time and for each code determined:

1. Whether it would fit within a previously identified basic theme
2. If it did, whether it would also fit within other previously identified basic themes
3. If it did not, what would be an appropriate label for a new theme that contained this code

I then wrote down any associated basic themes in the neighbouring column as shown in Table 2.

Table 2

Codes and Associated Basic Themes

Code	**Basic Themes**
a psychiatrist told me "there's nothing wrong with you"	Professionals dismissing the problem Sense of wrongness/unwellness
mental health professionals told me that gaming addiction was not recognised as an addiction	Professionals dismissing the problem Professionals seen as authority Recognition of gaming addiction
it was a big thing for me that the counsellors didn't think gaming was a problem	Professionals dismissing the problem Feeling like not being taken seriously

This table illustrates how the code 'it was a big thing for me that the counsellors didn't think gaming was a problem' was assigned to the basic theme 'Professionals dismissing the

problem' but also to the basic theme 'Feeling like not being taken seriously'. Grouping this code under the basic theme 'Feeling like not being taken seriously' required interpretation of the data based on my familiarity with the data set. Due to this familiarity, I was aware that this code came from a section of the interview in which the interviewee was describing their initial experience of discussing their gaming addiction with counsellors and feeling that they were not being listened to, and so I was aware that in this instance, "a big thing for me" referred to a sense of feeling like not being taken seriously. This could be confirmed by referencing the original segment of the transcription to which the quote is linked, in which the interviewee had stated "I do think that was a big thing for me, was they didn't think gaming is a problem, they're not taking me seriously".

This process of referring back to the original transcript was repeated frequently throughout the analysis to ensure the validity of the codes and themes identified, and to ensure that with each level of abstraction from the data set the meaning and intent of participants' words were not lost and not unduly influenced by my own bias.

By organising my data in columns, it was also possible to reorganise it so that I could easily see which codes were linked to a particular basic theme, as illustrated in Table 3.

Table 3

Basic Themes and Associated Codes

Basic Theme	**Associated Codes**
Professionals dismissing the problem	a psychiatrist told me "there's nothing wrong with you" at first I think the counsellors didn't see gaming as something to be interested in it was a big thing for me that the counsellors didn't think gaming was a problem mental health professionals told me that gaming addiction was not recognised as an addiction the therapists understood but did not accept being an addict the first time I saw a psychiatrist he didn't think there was anything wrong with me
Feeling undermined in treatment	I felt undermined a lot in talking about my addiction I felt undermined in treatment It's really undermining to treat gaming addiction as just depression

In the first example, I determined that the primary message being communicated by each code was a sense of 'Professionals dismissing the problem', and so this name was selected to represent this theme. Again, some codes were assigned to more than one theme where more than one meaning was significant.

This approach to identifying themes meant that the more codes I had analysed and assigned to basic themes, the less frequently I was creating new basic themes, since I had a greater variety of existing basic themes to which codes could be assigned. In addition, because of the

sheer volume of data, at times I inadvertently re-created themes which already existed. For example, I had initially created a basic theme called 'Feeling undermined in treatment', and another basic theme called 'Felt undermined in treatment'. To complete this stage of analysis I revisited every basic theme and corrected this duplication by renaming those basic themes which referred to the same codes to ensure that they had the same name. This reduced the total number of basic themes to 576.

3.5 Creating Sub-Themes

The next step was to further refine these basic themes and group them into more over-arching "sub-themes", a continuation of phase 3 of Braun and Clarke's phases of thematic analysis (2006, p. 89). This was a much more interpretative process than the previous stages of analysis, and involved a consideration of the content of each basic theme, an identification of patterns and interrelation between themes, and an application of my familiarity with the data set and knowledge of the topic area. At this stage, the 576 basic themes were grouped into 36 sub-themes, which involved a significant consolidation of the data.

A number of basic themes were also discarded at this stage of the analysis, based on lack of relevance to the research question. Up until this point in the analysis, all data had been retained if it related to treatment of gaming addiction or gaming addiction in general. However, since the research question was specifically focused on *experiences* of treatment of gaming addiction, at this point any basic themes relating to gaming in general that could not be seen as impacting on the experience of treatment were discarded.

As an example of this, the basic themes 'Gaming because of constant rewards' and 'Gaming due to desire to explore' were discarded, whereas the basic themes 'Gaming addiction kept

hidden' and 'Gaming seen as shameful' were not. Although these first two themes are certainly relevant to the treatment of game addiction since it is likely to be helpful for clinicians to understand the psychological drivers behind gaming, I believe that there is nothing in these statements that could reasonably be inferred as impacting on the participants' subjective *experiences of treatment*.

By contrast, although the second two basic-themes also do not specifically relate to treatment, I believe it could be reasonably inferred that both of these *could* impact on experiences of treatment. In the first case, if participants have typically kept their gaming addiction hidden, then it is likely that they may find it difficult and challenging to discuss this problem with a clinician. The same is true of the theme 'Gaming seen as shameful', and indeed due to my familiarity with the data I knew that one of the main motivators that participants named for keeping their gaming hidden was a feeling of shame. For this reason, both of these basic themes were grouped under the sub-theme 'shame and stigma'.

Further examples of this process of grouping basic-themes into sub-themes are illustrated in Table 4.

Table 4

Sub-Themes and Basic Themes

Sub-Theme	**Basic Themes**
Thoughts/experiences of clinician judgement	Becoming used to not being taken seriously Being judged as an impact of addiction Being laughed at by a professional Feeling disheartened over not meeting counsellor's goals Feeling like therapists were condemning me feeling pitied by professionals
Fear/anger about clinician intervention	Becoming angry with others interfering with gaming Fear that therapists would want to stop my gaming Feeling anger at anyone who pointed out my problem Feelings of being controlled
Fears about clinician efficacy	Belief that professionals might not give a diagnosis Belief that clinicians wouldn't treat game addiction Feeling frustrated about incompetence in treatment Professionals not being reliable Professionals not following through on promises Professionals not providing any solutions

As this table illustrates, the process of identifying sub-themes was subjective. Braun and Clarke (2006) note that in thematic analysis, a different researcher would likely have identified a different set of themes. For example, I made a subjective decision to use the

word 'judgement' in the sub-theme 'Thoughts/experiences of clinician judgement' to capture a multitude of different participant experiences that included feeling pitied, feeling condemned, not being taken seriously, and being laughed at. In doing so, I necessarily made a decision about the meaning of the word 'judgement' and its relevance to these basic themes. In this instance, I used the term judgement to mean the process of forming an opinion or conclusion, and attaching a moral or value-based valency to this opinion that was experienced as negative. As much as possible I attempted to mitigate the influence of my own subjectivity through careful deliberation and reviewing and re-reviewing the data through each stage of the process, to ensure that I was not deviating too far from the intent communicated in the initial data.

From the associated basic themes it can also be seen that I included experiences that could be externally validated from the participants' experiences as well as those which may have been solely based on an intra-psychic processes. For example, one participant's description of being laughed at by a doctor provides an experience of judgement that was externally reinforced by the clinician's behaviour, whereas a different participant describing a sense of being pitied by a clinician may or may not have experienced any specific behaviours from the clinician which contributed to this sense. That is to say that it is possible, though not assumed, that this sense of being pitied could have arisen in part from the participant's own sense of shame surrounding their addiction. In order to reflect these possibilities, I called this sub-theme 'Thoughts/experiences of clinician judgement' rather than just 'Thoughts about clinician judgement' or 'Experiences of clinician judgement'.

Table 5 provides a full list of sub-themes identified at this stage of analysis.

Table 5

Full List of Sub-Themes

Patient-driven treatment
Clinician knowledge/experience
Thoughts/experiences of clinician judgement
Becoming attached to clinician
Fear/anger about clinician intervention
Foreclosure or dismissal of gaming addiction
Belief in self as expert
Fears about clinician efficacy
Positive responses to treatment
Treatment environment
Qualities of good treatment
Motivations for treatment
Desire for recognition
Benefits of treatment
Fears about experience and outcomes of treatment
Identification and belonging
Insight & understanding
Availability of treatment and structural issues
Negative feelings in treatment
Shame and stigma
Impact of external factors/circumstances
Acceptance of self
importance of being heard
Facing feelings
Building new skills
Hope
Non-specific clinician qualities
Challenging the self
Accepting gradual change
Dishonesty in treatment
Challenges and resistance to treatment
Waking up to the problem
Professionals leading treatment
Need for clinician learning
Will
Separating self from addiction

Once these 36 sub-themes were identified, they were again assessed for relevancy to the research question by referencing back to the basic themes and codes that had generated them. A number of sub-themes were removed at this point due to their lack of specificity to the

treatment of gaming addiction. These sub-themes, while relevant to treatment, were identified as being relevant to any therapeutic treatment regardless of the presenting issue.

The following sub-themes were removed:

Accepting Gradual Change

Benefits of Treatment

Positive Responses to Treatment

Qualities of Good Treatment

Negative feelings in treatment

Impact of external factors/circumstances

Non-specific Clinician Qualities

Will

Challenging the Self

Motivations for Treatment

Many of these removed themes were generalizable to treatment for other issues and reflected the findings of research showing that there are a significant number of non-specific factors that contribute to positive therapeutic outcomes (Chatoor & Krupnick, 2001). Although these sub-themes were removed, at times there were basic themes associated with these sub-themes that were retained due to being contained within other sub-themes. For example, the basic theme 'Professionals taking game addiction seriously' was grouped under one of these discarded sub-themes as well as under the sub-theme 'Need for clinician learning' which was retained. In this way it was possible to exclude sub-themes that were too generic without losing data contained within those sub-themes that was specifically applicable to experiences of gaming addiction treatment.

3.6 Refining Sub-Themes

Following the removal of sub-themes that could be generalised to treatment for other issues, the remaining sub-themes were again reviewed to ensure that they were consistent with the data and accurately reflected the basic themes that had emerged from the previous stages of analysis. This was done by checking each sub-theme against Braun and Clarke's (2006) criteria for "*internal homogeneity* and *external heterogeneity"* to ensure that the basic themes contained within each sub-theme were consistent and relatable, and that each sub-theme was sufficiently different as to justify their separation.

A description of each of the remaining 26 sub-themes is provided below.

Patient-driven Treatment

This sub-theme related to participant statements about guiding and propelling their own treatment. I selected the word 'driven' to capture this dual-role of both guiding and propelling. Participants spoke about leading their own treatment in both positive and negative ways. In a positive sense, participants spoke about the value of flexibility in treatment, of being able to choose when and how to engage with treatment and being able to leave at any time, and also spoke about the importance of having internal motivation for treatment and of *choosing* to seek help. These positive factors are likely generalisable to treatment for other issues, and this sub-theme was primarily retained on the basis of the negative aspects which I felt were likely more specific to treatment for gaming addiction.

Participants spoke about having to advocate for themselves, having to confront their clinicians, having to try and convince clinicians to treat them, and having to learn how to treat themselves due to a lack of professional support. This linked closely with sub-themes relating to professionals dismissing gaming addiction, and several participants spoke about

this experience of feeling that they had to take a much more active role in their treatment specifically because of a lack of professional understanding and acceptance.

Clinician knowledge/experience

Participants spoke about a perceived lack of knowledge and experience amongst the clinicians treating gaming addiction. This sub-theme captured statements relating to the need for clinicians to learn about this topic, the importance of clinicians learning from each other, the importance of treatment that specifically relates to gaming addiction, the possibility of drawing on learning from treating other addictions, and also participants' expectations about clinician knowledge based on the age of the clinicians. Most of the research participants were younger, and expressed the view that they believed older clinicians would be less likely to understand or know about gaming addiction due to its relative newness as a phenomenon.

Thoughts/experiences of clinician judgement

This sub-theme related to participants' experiences of being judged by clinicians, or of feeling judged. The use of the phrase 'thoughts/experiences' reflects the fact that some participant statements described an interpersonal process, such as being laughed at by a doctor, while others described an intra-psychic process such as feeling as if a clinician was disappointed due to the client not having met their goals. Participants described experiences of being laughed at, as well as feeling condemned, pitied, or as if they were not being taken seriously.

Becoming attached to clinician

This sub-theme related to participant statements about becoming attached to a particular therapist or clinician. Participants spoke about feeling connected to a particular clinician, about feeling sad when treatment ended, and also about the importance of feeling good and

positive while in treatment. Although these concepts are certainly generalisable to treatment for other issues, this sub-theme was retained as I believed there may be specific factors in play that were unique to treatment of gaming addiction, in particular due to the emergence of parallel sub-themes relating to identity and belonging that seemed to be of significant importance. I made the decision to retain a number of themes for this reason, with the rationale that if it later seemed that they did not contribute meaningfully to the understanding of identified global themes that they could be discarded at this stage.

Fear/anger about clinician intervention

This sub-theme related to participant statements that expressed ambivalence about treatment, specifically fear or anger about how the interventions of the clinician might affect them and their gaming. Participants spoke about the fear they felt that others would try and control or limit their gaming, and the anger that they had experienced in the past when this had been controlled by others, whether family members or friends. Participants also spoke about the anger they had experienced towards anyone who identified their gaming as a problem. This theme seemed highly relevant for clinicians working with this problem, as it pinpointed a significant source of ambivalence in treatment.

Foreclosure or dismissal of gaming addiction

This was the largest sub-theme to emerge from this stage of analysis, in the sense that it had the single greatest number of basic themes associated with it. It related to participant statements about clinicians making what were experienced to be premature decisions or assumptions about gaming addiction, or clinicians dismissing the issue altogether. Participants spoke about having had experiences of being told that gaming addiction was not a real problem, of clinicians wanting to focus on depression or anxiety instead, of not being

taken seriously, of feeling ignored or as if their own experience had no value, of feeling that they had to 'break down' in order to be taken seriously, and of feeling frustrated about treatment that did not seem to address the 'real problem'.

Participants also spoke about their interpretations of what occurred in treatment, with a number of participants expressing that they felt that clinicians actively wanted them to have a 'normal' problem, that clinicians were uncomfortable with discussing gaming addiction because they didn't understand it, and that clinicians were motivated to try and persuade participants not to focus on their gaming addiction because of this discomfort.

Lastly, a number of participants also described clinicians simply not asking about or exploring gaming addiction, and suggested that it simply might not occur to some clinicians to ask about it.

Belief in self as expert

This sub-theme related to participants' statements about trusting their own judgement, and their conviction in the reality of their own experiences. Participants spoke about feeling confident that gaming was their 'primary' problem, feeling confident in talking with professionals because they were telling the truth as they saw it, feeling like the expert, and also about satisfaction that came from seeing clinicians developing a new perspective on gaming addiction by working with them during treatment.

Participants also expressed negative feelings about what they experienced as incompetency during treatment, and frustration that it seemed that those who they had gone to for help knew less about the problem than they did themselves.

Fears about clinician efficacy

This sub-theme relates to the previous one, and included participant statements about their expectations or experiences of clinicians being ineffective. Participants spoke about their belief that clinicians wouldn't take them seriously or wouldn't provide treatment, of experiences of clinicians not providing a diagnosis or appearing unknowledgeable about the topic, of clinicians not being reliable or not following through on promises, and of clinicians seen as unpredictable and motivated by payment rather than a desire to help.

Treatment environment

This sub-theme related to participant statements about the treatment environment. The majority of the included basic themes could be generalised to other treatments, but a number of themes did relate specifically to gaming. In particular, one participant spoke about the value of having a residential treatment environment in which computers were not readily accessible, and the value of having a treatment environment that was isolated from the rest of the world. Other participants also spoke about the ubiquity of computers and technology being a contributing factor to their addictions, and so the treatment environment in the broadest sense seemed to be relevant to the research question for these reasons.

Desire for recognition

This sub-theme reflected participant statements about a desire that gaming addiction be recognised, along with their struggles in overcoming it. Participants spoke about wanting others to acknowledge the issues they were dealing with, and celebrate their successes with them when they achieved a reduction in their gaming. Participants also spoke about the importance of others listening to them and being willing to learn from their experiences.

Fears about experience and outcomes of treatment

This sub-theme related to participant statements about negative treatment outcomes, either real or anticipated. Participants spoke about the difficulty of stopping gaming and a belief that treatment might not help with this, about the fears of what might be required in treatment including facing unbearable feelings or experiences, and about the fact that for one participant treatment did not seem to reduce the amount of time spent gaming even though other areas of their life improved as a result.

Identification and belonging

This sub-theme was the second largest to emerge from this stage of analysis, and related to participant statements about the importance of identifying with others and experiencing a sense of belonging. Participants spoke about experiencing identification and belonging both through their gaming and in treatment, although experiences were varied. Some participants spoke about a sense of identifying with people experiencing other types of addiction, while other participants spoke about feeling that they did not belong within addiction groups for other issues. However, most of the participants spoke about the value of discovering that they were not alone, that there were others like them experiencing similar difficulties, and the value of feeling accepted and supported by others whether this was clinicians or others receiving treatment.

Insight and understanding

This sub-theme related to participant statements about the importance of developing insight and understanding into their experience, and for many participants they spoke specifically of the value of developing an understanding of the psychological processes of addiction. Participants spoke about feeling 'liberated' when they understood addiction, about the

importance of information and education being available to gaming addicts in treatment, about the importance of self-reflection, about the value of clinicians asking questions and giving new information to think about, about the importance of identifying 'triggers' for addictive behaviour, and about the value of clinicians helping them to identify a separation between their sense of self and their addictive processes. Some participants also spoke about developing an awareness of their own addictive processes by observing them in others, such as friends or partners who were also engaged in gaming addiction.

Availability of treatment and structural issues

This sub-theme related to participant statements about the availability of treatment, or issues in the way treatment was structured or provided. Participants spoke about feeling scared or frustrated that there did not seem to be suitable help available, about finding it difficult to find funding for treatment since gaming addiction was not recognised by insurance or health providers, about the difficulty of finding others experiencing similar problems and establishing support groups, and about being advised not to discuss their gaming addiction when seeking help on the basis that it might lead to them being rejected for treatment.

Shame and stigma

This sub-theme related to participant statements about feelings of shame experienced during treatment or when contemplating treatment, as well as statements about the perception of stigma experienced by gaming addicts. Participants spoke about the tendency to keep gaming behaviours hidden, about fears of being judged or not understood by others, about the tendency for others to believe that it would be possible to 'just stop' their gaming, as well as about shame experienced both due to the gaming itself as well as consequences that arose from excessive gaming. Participants also spoke about their sense that there was a broader societal stigma against gaming, and particularly against excessive or addictive gaming.

Acceptance of self

This sub-theme related to participant statements about the importance of accepting themselves, and tolerating mistakes, inconsistency and uncertainty. Although these concepts could be generalised to treatment for other issues, this seemed to have a particular relevancy to gaming addiction given other statements participants made about making comparisons between an 'online' or virtual self, and an 'offline' or real self. This idea is explored further in the global themes section of this dissertation.

Importance of being heard

This sub-theme related to participant statements about the importance of being heard and genuinely listened to. This theme could also be generalised to treatment for other issues, however it again seemed particularly relevant to gaming addiction since participants' experiences indicated that in many cases they knew more about gaming addiction than did the clinicians treating them. For this reason, the importance of being heard was greater still due to the need for clinicians to hear participant experiences in order to develop their own understanding of gaming addiction and capacity to provide effective treatment.

Facing feelings

This sub-theme related to participant statements about the value and challenges of facing their feelings in treatment. Participants spoke about the difficulty of identifying their feelings, which may be particularly relevant to gaming addiction as other research has indicated that for many, gaming addiction has a numbing effect which enables gamers to tolerate difficult emotions but which also leads to a form of dissociation in which emotions can no longer be recognised or identified (Dalbudak et al., 2013). Participants also spoke

about the value of being required to confront their feelings in treatment, and of learning that feelings become more manageable or subside when they are tolerated rather than repressed.

Building new skills

This sub-theme related to participant statements about the value of developing new skills in treatment. In addition to participants discussing skills relating to understanding and managing addiction, participants also emphasised the value of developing social skills in treatment due to the social isolation that several participants saw as being inextricably linked with gaming addiction.

Hope

This sub-theme related to participant statements about the need for and value of hope in treatment. This related specifically to gaming addiction in that participants spoke about the lack of success stories and narratives of others who had overcome gaming addiction. Participants expressed that this made it more difficult to know what might be possible in treatment, and contributed to a sense that it was even more important that clinicians be supportive and that patients learn positive self-talk and encouragement.

Dishonesty in treatment

This sub-theme related to participant statements about non-disclosure or minimisation of gaming behaviours in treatment. Participants spoke about how feelings of shame led them to not disclose the extent of their gaming, as well as how they had developed behaviours of lying and manipulating others in their life in order to be able to spend more time gaming. Participants also spoke about realising through treatment the importance of honesty and disclosure to clinicians, and that this was engendered by an atmosphere of trust and respect.

Challenges and resistance to treatment

This sub-theme overlapped significantly with several others, and related to participant statements about their reasons for being resistant to treatment. Participants spoke about experiences of being judged or dismissed leading to resistance as well as about the impact of shame on treatment. Participants also spoke about their own ambivalence about quitting gaming, and the fact that for many of them they had been playing games since early childhood which made it a very difficult behaviour to change. Participants spoke about not wanting to burden others, about others not necessarily liking the changes they made to themselves in treatment, and also about the difficulty of 'giving up' an established online identity and the social connections that came with it.

Waking up to the problem

This sub-theme related to participant descriptions of a 'wake-up' moment where they became aware of the negative impacts of their gaming. Some participants described how they had reached the conclusion on their own that gaming addiction was a problem for them, while others spoke about how the questions and information provided by clinicians had led to this realisation.

Professionals leading treatment

This sub-theme related to participant statements about the experience of treatment that was primarily led by clinicians, rather than by the participant themselves. Participants spoke about clinicians setting a timeline for treatment, establishing goals, telling them what to do, and giving advice.

Need for clinician learning

This sub-theme related to participant statements about the need for clinicians to develop better understanding and knowledge of gaming addiction. Participants spoke about the need for clinicians to learn from their clients, to learn from each other, and to learn from research and literature in the field. Participants also expressed that they felt that when clinicians did not understand a topic, they were more likely to avoid it and steer conversation towards areas with which they felt more comfortable.

Separating self from addiction

This sub-theme related to participant statements about the challenge of separating a sense of self or identity from their addictive behaviours and thoughts. Participants spoke about the importance of being helped to make this distinction, as well as about the difficulty of leaving behind an online identity that they had established. Participants also spoke about the difficulty of separating gaming and socialising during recovery. That is, some participants found that because their social networks largely existed through or due to online games, it became difficult to maintain these social connections without this leading to a return to gaming. Participants also described finding it difficult to make new social connections, as some felt that the time they had spent gaming had led to a deficit in social skills.

3.7 Selecting Global Themes

Having reviewed and refined the sub-themes in the previous stage of analysis, I now moved on to the final stage, that of identifying and then refining global themes. Braun and Clarke (2006) state that, "By the end of this phase, you can clearly define what your themes are and

what they are not." (p. 92) and that the names given to themes need to be "concise, punchy, and immediately give the reader a sense of what the theme is about" (p. 93).

I approached this task of identifying global themes by moving away from a purely electronic method of reviewing the data. Each previously identified sub-theme was printed on a single piece of paper. I then laid out all of these sub-themes on a table, and began the first of several attempts at grouping these sub-themes into over-arching global themes.

I began by selecting a single sub-theme at random. I placed this sub-theme in an empty space on the table, and then selected a second sub-theme, again at random. I compared this sub-theme to the first selected sub-theme to determine whether there was any similarity between them in terms of content or in terms of theoretical links between them. If I believed that there was, I placed these two sub-themes together, creating the beginning of a new global theme. At this stage I made no attempt to define this global theme or give it a label, though I remained aware of the criteria by which I had determined that the two sub-themes were similar.

If, on the other hand, I did not see any similarity between the two sub-themes, I created a new group starting with the second sub-theme, so that I now had two piles of cards. This process was repeated for each subsequent sub-theme until all of them had been assigned either to existing groups, or to new groups.

Once this process was complete, I reviewed each created group of sub-themes in order to determine a short phrase or name that would effectively capture the essence of my rationale for grouping those sub-themes together. I wrote these names on new cards, and placed them with each created group. I then reviewed each sub-theme and compared it against the name I had given to the group to determine whether the group name accurately described the content

of that specific sub-theme when taken in isolation. In some cases this lead to sub-themes being moved from one group to another, and in other cases led to the renaming of groups. Finally, I took a photo of the finished grouping so that I could return to it at any stage. See Figure 2 for an example of the photos I took during this process.

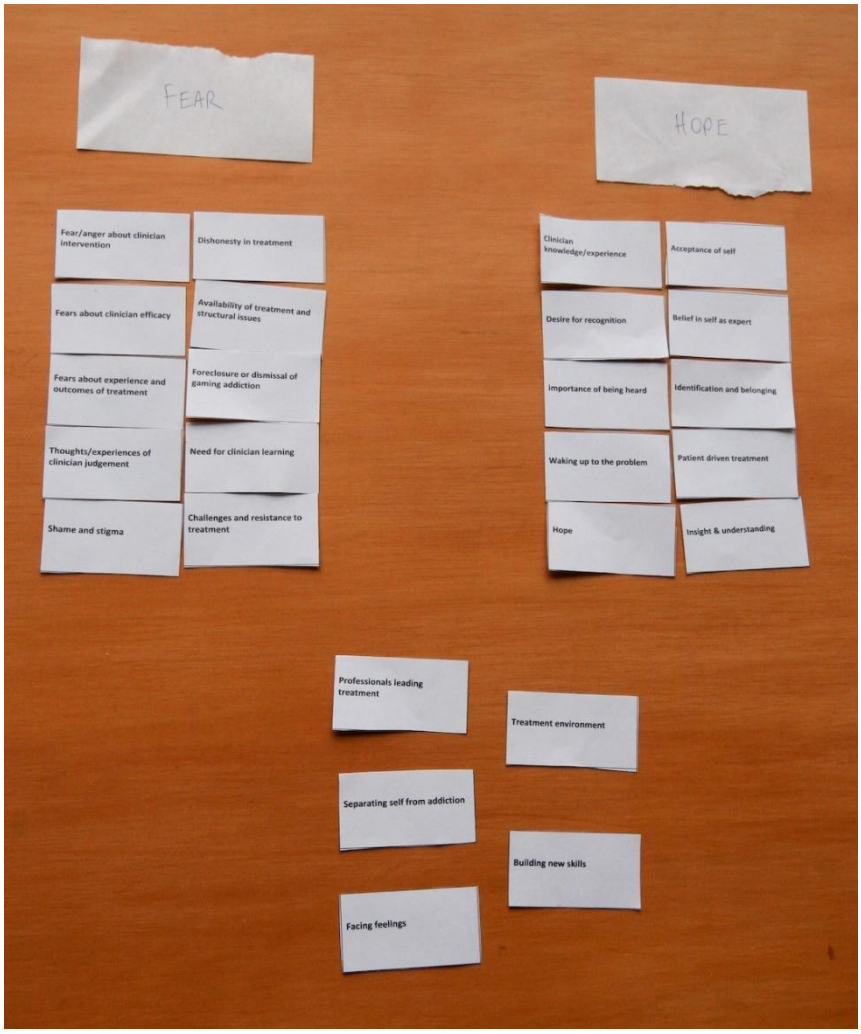

Figure 2. *Example of creating global themes.*

After this whole process was completed, I removed the group names I had created and put them aside, shuffled together all of the cards containing sub-themes, and began the process again beginning with a different random sub-theme. I repeated this entire process about ten times over a period of weeks, until it became apparent that no new possibilities for global themes were emerging from the data. A consequence of this method of analysing the data was that I was able to approach it from different perspectives each time I attempted the grouping process. What emerged from this was that while some global themes emerged only once during the multiple analyses, other global themes emerged repeatedly and seemed to demand recognition. In general, the themes that emerged only once appeared to be more generic and

generalisable to treatment for other issues, and so these themes were not included as significant global themes in the final analysis.

The following describes the process that I used to create the global theme 'Fear', as in Figure 2.

1. The first sub-theme I selected was 'Fears about clinician efficacy', so I placed this on the table by itself
2. The next sub-theme I selected was 'Fears about experience and outcomes of treatment'. This seemed clearly related to 'Fears about clinician efficacy', and so I placed this card next to the existing one.
3. The next sub-theme I selected was 'Importance of being heard'. This did not appear to relate to either of the two sub-themes I had created so far, so I placed this in a different space on the table to begin the creation of a second group of cards
4. The next sub-theme I selected was 'Shame and stigma'. Although this was clearly a qualitatively different emotion to 'Fear', it seemed related to the existing two sub-themes about fear as it seemed likely that gaming addicts' internal experiences of shame and their beliefs about stigma surrounding gaming addiction could lead to reasonable doubts and fears about clinician efficacy and what the experience of treatment would be like. I therefore grouped this card with the previous sub-themes.
5. The next sub-theme I selected was 'Need for clinician learning'. Again, it seemed possible to relate this to the previous sub-themes in that if gaming addicts believed that clinicians were insufficiently informed about the problem and needed further learning, then it would be reasonable to assume that they would have doubts or fears about those clinicians' efficacy.

6. I continued to repeat this process until all of the cards had been placed. As can be seen in the photo, five sub-themes were not assigned to either of the two major groups that emerged from this analysis as they did not appear to be related. Nor did these sub-themes appear to relate to each other in any meaningful way, and so I left them as separate sub-themes.
7. Finally, I selected names for the two groups of sub-themes I had created. As discussed below, these groups appeared to represent two opposing forces that either drove engagement with treatment and positive experiences of it, or which opposed it. In essence, these forces appeared to be fear and hope.

Through several iterations of this process, four major themes continued to emerge. Firstly, a theme emerged around clinicians dismissing gaming addiction, not taking participants' experiences of gaming addiction seriously, or prematurely shutting down an exploration and discussion of the role that gaming played in participants' lives. This stemmed both from participants' real experiences of being dismissed or the issue of gaming not being explored, as well as from participants' expectations and assumptions about how clinicians would respond to them, often based on past experience and attitudes to gaming addiction that they perceived in wider society.

The second theme that emerged related to participants' feeling judged, condemned, or shamed by clinicians. Again, this arose both from real experiences, and from beliefs and expectations that were in many cases driven by participants' own shame about their gaming addiction, and by stigma that was perceived towards gaming addiction in wider society.

The third theme related to participants' belief in the validity of their own experience, their recognition of their own deep knowledge about their own problems and psychological processes, and their trust in what they saw, thought and felt.

The final theme that emerged repeatedly related to participants' feelings about the importance of experiencing identification with others. This arose from participants' developing a deeper understanding of their own processes through recognising them in other people, participants' realising that the challenges they were facing had been faced and overcome by others, and participants not feeling isolated during treatment and recovery.

As it became apparent that these themes were significant, my first inclination was to identify these four themes as the main global themes reflecting the data. However, during one of the grouping exercises, shown in Figure 2, it resulted that I had assigned almost every sub-theme to one of two groups. In attempting to name these two groups, it became apparent that what they represented were two conflicting forces. One of these forces compelled participants to seek treatment and to believe that it was possible to overcome their problems, while the other force opposed this, and led to participants feeling doubtful about the possibility for recovery, and shamed and despondent about the problems they faced.

One of these groups I quickly named 'Hope' as it already contained a sub-theme with this same name, and this word seemed to capture the sense I had that these themes represented a motivating force for treatment, and an expectation or belief in the possibility of a positive outcome. It seemed on reflection that all of the sub-themes in this newly created group could be conceptualised as being different expressions of this hope, and so 'Hope' became one of my first global themes. It should be noted that although I simply called this global theme 'hope', in keeping with the research question this theme specifically relates to hope *for and about the treatment.* The same is true of the second global theme, 'Fear'.

This second global theme of 'Fear' I also named based on the fact that this word was contained within several of the corresponding sub-themes, such as 'Fears about clinician efficacy' and 'Fears about experiences and outcomes of treatment'. Moreover, in

conceptualising the two groups of sub-themes as feelings that either motivated patients to seek treatment or led them to avoid it, I found myself considering what feeling would oppose a sense of hope, the global theme that I had already identified. In doing this, it seemed apparent that the most appropriate word would be 'Fear', and so for these reasons I selected 'Hope' and 'Fear' as my two global themes.

It seemed then that rather than being global themes, the four previously identified themes were perhaps more appropriately conceptualised as sub-themes under these broader headings of hope and fear. Hope for the treatment was primarily present when participants experienced belief in the validity of themselves and their own experience, and when they felt a sense of identification and belonging with others. On the other hand, fear of the treatment was primarily present when participants experienced being dismissed or judged.

At first I was hesitant to select 'Hope' and 'Fear' as global themes, as they immediately seemed too generic and quite clearly applicable to all forms of therapy. Regardless of the issue, patients are likely to feel motivated to seek treatment by their hope that their problems can be resolved and that treatment will assist with this, and are likely to avoid treatment if they fear that it will not help or that it will be a negative experience. However, on reflection it seemed clear that not only did these themes fit the data, but that they also revealed something interesting about participants' experiences. The fact that these global themes could be generalised to other issues illustrated that perhaps the ambivalence that gaming addicts felt about seeking treatment was essentially similar to the ambivalence experienced by all therapy patients. At the same time, the sub-themes connected to 'Hope' and 'Fear' in this study illustrated that there were quite unique issues that *were* specific to gaming addiction that contributed to experiences of hope and fear which were not universal, and had significant implications for clinicians working with gaming addiction.

A final conceptual map of these global themes and related sub-themes could then be created, as shown in Figure 3.

In the following chapter, I will discuss the meaning of these two global themes and four sub-themes in depth, with excerpts from the interviews to illustrate their significance.

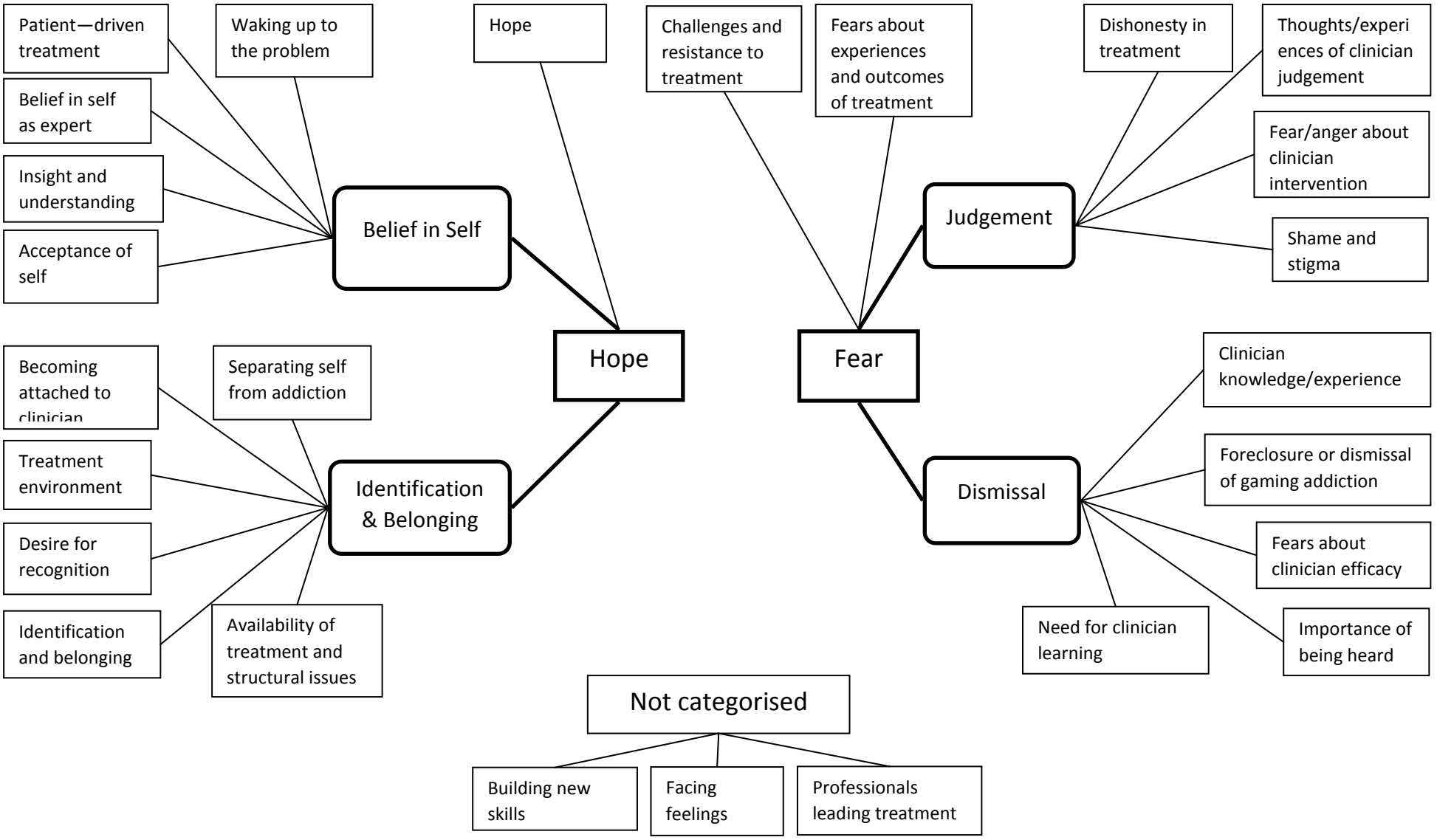

Figure 3. *Map of final global themes and sub-themes.*

4. Results

4.1 Introduction

In this chapter, I will outline the main findings of the research with reference to the original transcripts. Two global themes were identified, 'Hope' and 'Fear', each of which contained two corresponding sub-themes. The sub-themes 'Belief in self', and 'Identification and belonging' were associated with the global theme of 'Hope'. The sub-themes 'Judgement' and 'Dismissal' were associated with the global theme of 'Fear'.

While these global themes could in some ways be generalised to treatment for other issues, the sub-themes associated with each global theme revealed quite specific factors that influenced participants' experiences of hope or fear in treatment. Accordingly much of this chapter is dedicated to an in-depth exploration of these sub-themes.

4.2 Global Themes and Sub-Themes

4.2.1 Hope. The first of two global themes to be identified through this research was 'Hope', which Oxford English dictionary defines as "a feeling of expectation and desire for a particular thing to happen" (Oxford University Press, 2014). In the broadest sense, this could be seen to capture the underlying motivation of many if not all patients seeking psychotherapy. Hope describes a belief that it is possible for things to be different and that the change patients desire can be achieved. This clearly does not just apply to patients seeking treatment for gaming addiction, but to anyone who seeks help of any kind, and for any cause. This drive to seek help would not exist if there were not at least some belief in the possibility of change or improvement. Indeed, we have long been aware of the passive

resignation that tends to result when hope is no longer present, a behaviour often referred to as "learned helplessness" (Seligman, 1975).

Various authors have explored the significance of hope in psychotherapy (O'Hara, 2013; Babits, 2001; Bergin & Walsh, 2010). While some of these authors focus primarily on the positive role that hope serves in psychotherapy (O'Hara, 2013), others (Babits, 2001; Bergin & Walsh 2010) also discuss the possibility of hope as a regressive or problematic trait that can impede therapeutic progress due to the hope for a "magical, omnipotent solution to one's problem" (Babits, 2010, p. 349) that therapy cannot deliver. In this research, participant statements about hope presented it in a purely positive light, as a force that motivated them to engage in treatment and in making positive changes in their own lives. Participants did not at any time explicitly state or imply that they believed in the possibility of a 'miracle cure' through treatment, and if anything the reverse was true. In general, participants expressed low expectations about the possibility of successful treatment, as was reflected in the global theme of fear which I will discuss later.

What makes hope important to the treatment of gaming addiction beyond its universal significance in motivating help-seeking behaviours are the specific factors that contribute to patients' sense of hope. As the sub-themes 'Belief in self' and 'Identity and belonging' reveal, there are potentially unique factors that contributed to participants' sense of hope in treatment.

However, participants themselves also spoke of hope in a more universal sense. One participant spoke about her despair, and how important it became to find hope when in the depths of that despair. She stated, "I didn't want to give up, I wanted someone to tell me that there was hope and that I could stop gaming and I phoned everyone and I ended up finding someone that gave me that hope, I got… I think I got really lucky".

The same participant also spoke about the importance of hope in creating motivation to seek help, stating, "It was amazing talking to that guy, like he gave me so much hope. This was on a day when I didn't even feel like gaming cos I was feeling so ill. I was just laying in bed and my phone just started ringing I said 'Hello, (name) speaking?' and he really gave me hope and he gave me the strength I needed to, you know, pull my finger out and get help".

Participants also spoke about times when their hope was diminished by their experiences. One participant spoke about how his own internal processes led to feelings of hopelessness when he became aware that he was thinking about gaming even while trying to give it up. He stated, "It just felt hopeless when you're giving it up and then you have thoughts in your head about... games and things".

Another participant spoke about feeling that her hopes had been dashed when she felt as if she was not understood by the clinicians working with her, stating, "It really dashed my hope actually, thinking 'Oh my God these people don't know what I'm going through, they can't help me'".

In addition to speaking about hope directly, participants also discussed it indirectly. One participant described having experienced a number of negative interactions with people in her real life that contributed to her wanting to stay home and spend time on the computer where she felt safer, but then also expressed the importance of hope when she stated, "I do encourage myself and I see the positive side of life, I see well there are still reliable people, there are still kind people - not everybody's a jerk, not everybody's not nice, and I need to see this aspect of life in order to keep going".

Another participant described how it gave him hope to discover that other people had experienced gaming addiction, a theme that will be discussed in greater depth in the

following section, but also named how his hope was diminished by the fact that "these actual people exist, and they're doing with the same problem I am... yet there were very few success stories. Very, very few success stories".

4.2.2 Belief in self. As will be seen, some of the major factors that contributed to participants' doubts and fears about treatment were the experiences they had of not being taken seriously, or of being judged or dismissed by professionals. In contrast to this, one of the major factors that led to participants continuing to try and improve their situation despite these doubts was a belief in themselves and in the validity and truth of their own experiences. This factor is represented by this sub-theme.

One participant spoke about how despite feeling that she was not being taken seriously, she held firm to her own perspective on her problem, stating, "I think that my idea of gaming being the problem for me had quite a strong resolve, it was a core belief that gaming was as bad for me as alcohol for an alcoholic so that wasn't shifted". This resolve and internal conviction seemed to play a crucial factor in participants' positive experiences of treatment, since in many cases participants' narratives revealed that they had frequently needed to persist in seeking appropriate help beyond their first attempts, which were often met with dismissal or disinterest.

This belief in the validity of one's own experience was also reflected by a different participant when I asked her how she felt about discussing her experiences of gaming with me, and she responded by saying, "I am feeling confident, because I am feeling the truth, and I am telling what can happen to people in this life". This theme was repeated throughout the interviews, as participants consistently expressed faith in their own perception of their experiences, even if they acknowledged a lack of understanding of these experiences.

Participants described this as being one of the factors motivating them to seek professional help, as many of them desired to develop a better understanding of their circumstances.

Due to the lack of clinical familiarity with this topic amongst many clinicians, it seems more crucial than ever that clinicians do attempt to hear and understand their patients' perspective. One participant spoke specifically about this, stating that once she felt heard and that treatment was being matched to what she experienced that "I started to sort of have a new lease of life really. And they, the treatment centre did acknowledge, well from what you describe it does sound like you have a really extreme addiction". Another participant described a similar experience once he had found a counsellor that listened to his experiences, stating, "At some point I found the right professional for me… she took it like really seriously, she didn't even question about if the addiction was real or that it was the gaming part, like it's not... like it's a stupid thing or like it's not a real addiction".

Participants also spoke about the experience of feeling that they knew more about gaming addiction than the clinicians they were working with, which seemed to increase those participants' confidence in their own viewpoints and the importance of managing their own treatment, but was simultaneously experienced as disappointing and frustrating. At times this led to participants' experiencing that they had to confront or attempt to convince clinicians in order to be taken seriously. One participant stated, "It was frustrating, cos I felt like I had to advocate for my own addiction and so I think I was definitely the expert on gaming addiction".

Another participant stated, "Because I'd spent a lot of time under the mental health district y'know, under their care so I knew there was nothing like that available. If I'd known that there was... which there isn't... but if I'd known that there was, I would have taken it but I just did it... did it on my own really".

Participants also spoke about ways in which treatment that was experienced as helpful developed this belief in self further, and how the development of insight alongside a belief in the validity of their own experience was often found to be beneficial. One participant stated, "It felt so liberating that I understood it, like now that I can see it, I can understand it, I can touch it. I was much more... like my life, my life turned around, like absolutely, 100%, I was enjoying every part of my life much more then". He went on to state, "I just need to grow stronger at the moment, and I'm doing it all the time... like I feel, even though I'm not strong enough to stop completely playing, I'm now strong enough to have days that I don't play at all"

One of the other ways that this theme of belief in self was expressed was in participants' statements comparing their sense of themselves when gaming to their sense of themselves when not engaged in this activity. One participant described a significant difference in perception of his online versus his offline self, stating, "My whole sense of self worth was just so much bigger in the video games for me, than my real life". He went on to describe this disparity, stating, "There was such a large disconnect between your online persona and your real life sense of worth. Your persona's increasing but your real life is suffering. As soon as you put your head in the pillow you're... goddamn you're depressed. You're just so depressed and because you, I mean you know that when you turn the PC off, your life is nothing, really. You just have no sense of self worth, and the depression just comes at you like a sledgehammer, smacks you in the face".

The implications of this theme therefore appear to be that while a belief in self can be a significant source of hope for some patients, experiences or expectations of dismissal by clinicians can in many cases undermine this belief. In addition, the disparity that exists between the belief in self that some patients feel through their online self compared to their

offline self could likely mean that some patients do not have the degree of self-belief and certainty necessary to continually advocate for themselves in the face of repeated rejections or dismissals. Participants described a correlation between a strong belief in self and positive treatment outcomes, and so it will be crucial that clinicians working with this client group are aware of the factors impacting on patients' self belief.

4.2.3 Identification and belonging. The second sub-theme that I identified as a source of hope for participants in treatment related to a sense of identification and belonging. Some participants spoke about the strong sense of identification and belonging that they had felt through the online communities they were a part of during their gaming, and also about the difficulty of leaving this behind during their attempts to reduce their gaming. Participants also spoke about the importance of feeling that they had a place in treatment, that they belonged, and how off-putting it was when this was not experienced. Lastly, participants spoke about the importance of finding others who they could identify with in their recovery, and about finding a sense of identification and belonging with other recovering addicts.

Not all of the participants interviewed played online games, but those who did spoke significantly more about this theme than those who had played single player games. Specifically, these participants named the sense of belonging and community in online games being a major motivator for playing. One participant stated, "It just seemed like people were just really, really, friendly, and you could like ask people questions and people wanted to help you and there was just a sense of community". Another stated, "What I wanted the most out of it was for other people to recognise how good I was. And some reassurance that wow, that was really good, you're really cool, y'know. There were thousands of players that played this game. And people would... I would deliberately leave my messaging on to public and people would, other people would message me saying like 'Oh cool, y'know can I have some free

stuff?', 'Oh wow how did you get so strong in gear' and then people would say to me, other people from around the world they would message me and say 'You're my idol' they would say. And that happened on multiple occasions, and those were the best messages really".

This participant went on to describe how his online persona had become a much greater source of identity for him than his real life self, stating, "It was all about, y'know your online name. But I always had to be the best at it. If I wasn't gonna be the best, I wasn't gonna even touch it."

This same participant also spoke about how much more difficult it became to quit gaming due to this identification with an online persona, and the sense of belonging that the online community had created. He stated, "Your social circle is online. You can't, y'know, you try and deal with it as a big package but y'know you can't give up the… you're actually destroying... you're trying to get rid of your social identity cos that's all you've got is your internet persona social identity, you're trying to give that up. Because if you don't give it all up, you're gonna be pulled back in".

These participants who had been involved in online gaming also spoke about the importance of finding others who they could identify with during treatment. For one participant, this was other drug and alcohol addicts who they met in residential treatment, and for another it was people who they found through an online group for recovering gaming addicts. The participant in residential treatment spoke about her experiences and described how she felt both a sense of belonging with other addicts, but also at times a sense of not being understood. She stated, "I really felt identification with the drug addicts and the alcoholics, and I said no I'm one of them, don't set me apart from them because this is where I belong, this is my tribe, these are my people". On another occasion, she described how despite this sense of acceptance and interest, she still wanted to find others who could more directly relate

to her experience of gaming addiction.

> P: My sponsor in Coda is very interested in, like you know my video game addiction because it's a completely foreign concept to her and I think people like to hear the story. But, I don't think people really understand like the nitty gritty gaming stuff. Which I kind of you know, I can share about it in the Olga meetings but you know, not quite to the same extent, like I can talk about using dreams and things like that because it's something that everyone knows about, but it's the nitty gritty of like stuff that is difficult and is a bit isolating.
>
> I: Do you mean things like the sort of psychological motivations of being needed by the guild, or that sort of thing?
>
> P: Yeah, yeah, exactly, exactly. And that that need to belong. I got a feeling that drug addicts don't take drugs because they have a need to belong.

The other participant who had been heavily involved in online gaming also spoke about the value of identifying with others, going so far as to say that he felt that this was the single most important factor in treatment.

> P: I mean, I think the number one thing is, y'know, by far the number one thing, the greatest aspect is the empathy approach, really. From what... that's my experience.
>
> I: Can you say a little about what you mean by that?
>
> P: Having people to relate to, so like therapy groups. I think they'd be a great place to start. Therapy groups for maybe... y'know, y'know therapy groups. Because you've got people you can relate to. Yeah, you got other gamers you can relate to, cos it's so

> different from real life, the internet persona. You need to be able to relate to someone that's going through it as well.

He also described how coming across others who were attempting to quit gaming was a major turning point in his own recovery.

> P: That was the turning point really, that oh wow other people have actually had to do this.
>
> I: So realising that it was something that actually existed beyond just yourself?
>
> P: Yeah, knowing that there were other people doing it and the sense of encouragement that you got from these other people, that said 'Oh y'know just do it man, you'll feel great'.

This theme resurfaced repeatedly during the interviews, with participants making statements such as, "For the first time in my life I was able to like identify with someone else", or, "I think that was the most helpful part, was knowing that he'd suffered, cos he'd suffered a lot, he'd been through some really tough stuff, and he'd got through it and he was now on a healing journey, trying to help other people as well", or, "The only thing that really made me look at it as an addiction was the stopgaming subreddit and seeing, reading these experiences of other people."

However, not all participants experienced a sense of belonging within these recovery communities. One participant had attended a 12-step meeting and found that, "There were a lot of people who were like drug addicts, or alcohol addicts so they didn't feel like my addiction is real, or like I felt like I was a phony or something like that, that doesn't... it didn't feel good to be there".

It was clear that for some participants, finding a sense of community in recovery was crucially important, possibly as a replacement for the online community that they were leaving behind by quitting gaming. For other participants however, the sense of identification and belonging related more to a sense of feeling accepted by clinicians, and that there was a place for them in treatment.

One participant described this as welcoming gaming addicts, stating, "I think you know it's about welcoming gaming addicts and saying 'You think you've got a problem, we're gonna help you'". Another spoke about two very different experiences he had had with different counsellors. He described how with one counsellor, "It felt like they were watching someone who had like... like you would watch a dog who has only three legs, like you are 'Oh, damn', like you really feel bad for it". On another occasion he described a counsellor with whom he felt a much greater sense of acceptance and belonging, stating, "It felt really open, like she made me feel really comfortable. And I was able to talk about anything. And it like really felt like, like a friendly place, like I wanted to go there, like every time we had a meeting, I would like be happy to go there". He described how in working with this counsellor he began to internalise her voice due to the identification he experienced, stating, "We talked about things and she gave me questions to think about and some of those questions were like really, like deep in me. Like wow, I still today have some of those words and questions that go up in my head".

It is clear from participants' narratives about their experiences that identification and belonging are an important aspect of recovery, particularly for gamers who have primarily played online games. Clinicians need to be aware that for these gamers, overcoming addiction will mean not just giving up the games themselves, but also separating themselves from what one participant named as "99% of my social life". For this reason, many

participants found it beneficial to connect with others who were going through similar experiences, whether it was gaming addiction or recovery from drugs and alcohol. However, due to the lack of groups specifically targeted at gaming addiction, many participants struggled to find a place where they felt as fully understood and accepted as they would have liked, often experiencing groups developed for other addicts to be partially helpful but also alienating at times. Due to these experiences, clinicians will need to be particularly mindful of creating a space in treatment where gaming addicts feel they belong and are accepted, so that a positive identification with the clinician can develop.

4.2.4 Fear. The second global theme identified in this research was 'Fear', which Oxford English dictionary defines as "An unpleasant emotion caused by the threat of danger, pain, or harm", or, "A feeling of anxiety concerning the outcome of something" (Oxford University Press, 2014). In this case, the danger or harm that is anticipated was largely reflected in the two sub-themes of judgement and dismissal. Participants expressed fear that their attempts to seek help would be met either with condemnation, pity and shaming, or with dismissal and condescension. As with hope, this theme likely reflects an emotional factor that contributes to avoidance of treatment for a wide range of issues, and so understanding its specific relevance to gaming will rely on an investigation of the underlying sub-themes. Unlike hope however, it seems that little has been written on fear in psychotherapy where it relates to fear of the therapeutic process, fear of the clinician, or fear of judgement. Where fear has been explored in psychotherapy writing, it seems it has generally been done so from the perspective of exploring fears that the patient may have about other areas of their life rather than the treatment itself (Greenberg, 2002).

In addition to participant narratives about their fears of how clinicians would respond, some participants also described experiencing fear about the possible outcomes of treatment, and in

particular fears that successful treatment might mean a reduction in time spent gaming. One participant stated, "I didn't want them to tell me 'Wow, what you're playing that many hours in front of a game? That's not healthy, you gotta stop'. And I was dreading that. I didn't want to give it up". Participants frequently expressed this ambivalence about treatment, demonstrating that although they were at times highly motivated to overcome their gaming addiction, at other times they were resistant to this change. Another participant stated, "I think if someone just took the games away from me, said you're not going to do that anymore, I would resent them, I would hate them and I would find a way, because I... I'm an addict".

One participant also expressed fears about being submitted to treatment involuntarily if he was honest about his situation, stating, "I didn't first tell them about it because I thought they wouldn't believe it, or it would mean like bad thing for me, like they would throw me to some crazy house or something."

Participants also spoke about fear as it related to their gaming itself. In one case, a participant spoke about her fear of the world outside of gaming as a motivator for continuing to game, stating, "I am thinking while I am going to get out there and who knows what I'm going to see or what is going to happen to me. But most of the time when I need to leave the games for people I feel positive, I go happy thinking that things are going to be fine, meeting the people that I meet. But sometimes I could be much better off exposed to the games than meeting people." Another participant expressed a similar sentiment and added that a fear of facing feelings contributed to a desire to continue gaming. She stated, "The sharing is all the same and people talk about the same things and it's not being able to feel your feelings, and being afraid of your feelings and I think it's because people get sort of scared of society and

overwhelmed and there's not a lot of support out there for people that feel like they don't fit in, and they don't understand and... yeah... [laughs] it's a scary, a scary thought".

This last quote illustrates another source of fear that participants described, a fear that help and support would not be available to them.

At another time this participant also spoke about how she feared that the severity of her addiction could kill her, stating, "I couldn't carry on like that, and that the way I was going I was probably going to die".

4.2.5 Judgement. The first sub-theme that contributed to participant' experiences of fear was 'Judgement'. This sub-theme related to participant beliefs and experiences of being judged, condemned, pitied or otherwise evaluated in a negative way. Participants described experiences of being judged by clinicians and by others in their life, but also spoke about their internal self-judgements that arose from the shame they experienced about their gaming addiction.

Fear of clinician judgement was spoken about by nearly every participant, and many described first-hand experiences of feeling judged by a clinician. One participant stated, "They would go to the doctor and the doctor would be very happy to have people come and pay a fee of around forty dollars, and not even give them a diagnosis or, it happened to me to go to the doctor and be laughed at by the doctor". Another participant stated, "There were several professionals so it was more of a bit like rough love. What should their style be like, they were quite punishing for me or like they made me feel really bad for the addiction".

Another participant described how he felt shamed by clinicians reacting in shock to his gaming, and how this would lead to being dishonest about the amount of time spent gaming.

I: Can you give me an example of what happened when you brought up the fact that

> you spent quite a lot of time on the computer with the counsellors, how did they respond to it?
>
> P: On the times that I'd bring it up, cos they would ask how many hours you'd play, you'd be on the computer, and you'd lie, and just... you'd always say like about half to two thirds of the amount of time that you'd play, and even that would be a lot. And so then they would say 'What!' and they'd have a look of shock on their face, and saying 'It's bad y'know you should just gotta get some sun instead'. They didn't offer any... they didn't wanna go into it, they just kinda said, that's bad, you should stop, really, it's not good.

In addition to describing feelings of judgement from clinicians, participants also spoke about feeling judged by others in their life for their addiction, and how this contributed to an expectation that clinicians would judge them as well. One participant stated, "I just didn't want people to know, or people to judge me, and the only time I'd really talk about it was when I heard other people talking about it and then I would say [whispering] 'Oh, I play that too, what's your name?' and it would be very under the table, and I think that's why I felt like I was living a double life". Another described how judgement felt like a constant factor as an addict, stating, "(An) addict's life is pretty much just judgement all around, in school, in work, with family, with friends, everyone is judging everything you do, because you fail all the time".

This experience of judgement extended to a more global belief that gamers and gaming addicts would be judged, as several participants spoke about their experiences that there was a universal stigma surrounding gaming and game addiction. One participant stated, "There's such a massive stigma around video game addiction, and it's all hush-hush cos you can do it behind closed doors, it's so private". Another participant described how this expectation of

judgement led to a significant amount of shame when he first spoke about his gaming addiction with a counsellor.

> P: I was partly surprised that it went so easy and partly of course like insanely ashamed of it, because it was pretty much the first times I had told it to someone
>
> I: So it felt shameful to talk about it with somebody else?
>
> P: Yeah, and it still does

This expectation of judgement and patients' own internalised sense of shame surrounding gaming addiction have obvious implications for clinicians working with gaming addicts. Participants made it clear in their narrative that fear of judgement and shame led in many cases to dishonesty in treatment about their situation, which could impede an effective working alliance with a clinician. Clinicians therefore will need to be mindful both of patients' vulnerability to feeling judged and shamed, and also of their own beliefs and attitudes towards addiction in general and gaming addiction specifically so that they are able to create an environment in which patients do not feel judged. When it was possible to do this, participants experienced treatment as much more positive and described themselves as being much more likely to continue with it, as described under the sub-theme of identification and belonging. One participant was quite explicit about this, stating, "When they condemn my mistakes, it just makes me feel worse about it and I don't want to come again".

4.2.6 Dismissal. The second sub-theme that contributed to participants' experiences of fear was 'Dismissal'. This sub-theme related to participants' experiences of feeling dismissed or not taken seriously by clinicians. Sometimes participants described this dismissal as overt, whereas at other times participants described experiencing this in more implicit ways from clinicians, such as experiencing clinicians as being uncomfortable talking

about or exploring gaming addiction in depth, or by clinicians placing greater emphasis on other issues that they believed to be of greater concern. In general, this theme of dismissal was experienced by participants as clinicians prematurely making conclusions about the nature and role of gaming addiction in participants' lives, and foreclosing on any detailed exploration of the topic. This frequently led to participants fearing that they would not be taken seriously or would not receive appropriate treatment, or that clinicians were not sufficiently informed or equipped to be able to provide effective treatment.

One participant spoke about her first experience of trying to get clinicians to acknowledge her gaming addiction, stating, "Well I kind of felt undermined a lot, because when I spoke about my gaming addiction, people didn't really understand. Like they said 'Oh well, we just think that the problem is anxiety and depression sort of thing'. Like, no no no... gaming addiction is a deep problem in me, and it kind of felt like I was sort of being ignored". The same participant described how when she first attempted to get treatment, she was told that there was no point in going as there was nothing wrong with her, stating, "He actually said 'Well there's nothing wrong with you, there's no point you coming here' and I actually broke down and he invited me to come back for a second interview".

Another participant described his sense that the clinicians who were treating him perhaps understood his addiction, but did not accept it, stating, "It felt like they didn't understand how is it to be an addict, or like they understood it but they didn't accept it", and that, "Even some of the therapy professionals even act a bit like they don't take it seriously".

When asked about why they thoughts clinicians might not take gaming seriously, some participants stated that they felt clinicians might stick with what they knew due to a lack of familiarity with gaming addiction.

I: So at first, what was your perception of the staff's response, or beliefs about the gaming addiction?

P: I think at first they just thought that the gaming addiction wasn't anything to be, you know, interested in. You know, I don't think any of them had experienced gaming addiction themself so they didn't really understand it, and most of them were alcoholics that were in recovery, so they sort of… I don't think they understood that it was the same experience, perhaps? Just I guess you know addiction has many different forms so you know people aren't going to know about all of them but I think it was just because they didn't know that it was the same, so they stuck with what they knew which was anxiety and depression.

Another participant described a similar experience, stating ,"They didn't offer any... they didn't wanna go into it... it was just kinda like told what to do, instead of going into it and dealing with it". Some participants also suggested that clinicians might be more inclined to dismiss gaming addiction or not take it seriously due to beliefs in the wider community about the validity of gaming addiction. In part this related to the previously discussed lack of an official diagnosis for gaming addiction.

I: So what had held you back from mentioning your gaming problems to people before?

P: I think it was that I didn't realise that it was a recognised addiction. I didn't realise that there was help out there, even when I was seeking help, people would say, oh don't tell them that it's gaming addiction, tell them that it's anxiety and depression.

I: Who told you those things?

P: Mental professionals, counsellors, doctors, yeah, yeah they said we think that the

> problem here is anxiety and depression because I don't think that gaming addiction is a recognised addiction in the UK.

This dismissal of gaming addiction was also experienced in relation to participants seeking funding for treatment. The same participant as above stated, "When I was talking to the Lifeworks admissions counsellor, she said 'Okay so what's the problem, why do you want to come to (treatment centre)?' and I said 'Oh well it's anxiety and depression, but there's also gaming addiction' and she said well okay, when you go to write your claim, I want you to put anxiety and depression because they won't take gaming addiction seriously".

Participants also described what they perceived to be prevailing attitudes of dismissal towards gaming addiction. One participant stated, "Pretty much everyone didn't understand it and they didn't take it for real", and that, "If I would have a drug addiction, then everyone would be like oh my god let me help you. Everything would be alright, but if I tell about a gaming addiction they're like 'lol' (laughing out loud)". Another described how a lack of awareness of the problem could lead to many people still suffering from it, stating, "I can see why people still suffer with it, because you know, it's not recognised as a problem, people don't know that it's a problem".

Lastly, participants also spoke about how a lack of availability of specialised services led many of them to expect that they would not be taken seriously. One participant stated, "I'd felt that there was nothing available. I looked, I looked online to see if there were any video game addiction sites, even groups. But they were very limited, so I knew that there was nothing to do with... any therapy".

Participants also described the impact of this dismissal of gaming addiction, and indicated that for many of them it led to ineffective treatment. One participant stated, "Through my

experience with a number of the therapy approaches, none of them touched on video game addiction, they all touched on feelings, or some of them touched on like things that would happen in life, y'know, things that would happen as a kid. But none of them helped, none of them... they just glossed over the surface really". Another expressed how important it felt to her that clinicians acknowledge gaming addiction as a problem, stating, "I think that they need to acknowledge that it is an addiction, and that it is a problem, and that it's the same disease as alcoholism and other addictions. I think that if they acknowledge that, I think that would be extremely powerful… …missing gaming addiction and saying you know, oh it's not gaming addiction it's just depression… it's really undermining".

Clearly, this theme has implications for clinicians in terms of being informed and aware about the possibility of gaming addiction, and being open to hearing and accepting participants' descriptions of their own experiences. As gaming addiction is still not well researched or understood as a clinical concept, it will be important that clinicians remain open to learning from their patients, as participant narratives clearly show that treatment was experienced as being more effective and meaningful when it aligned with participants own experiences and understanding of their problems. When participants experienced that they were being taken seriously and that their clinicians had an interest in exploring and understanding gaming addiction alongside them, treatment was experienced positively and participants remained engaged.

4.3 Conclusions

This chapter has described two global themes of 'Hope' and 'Fear', and four sub-themes related to these global themes: 'Belief in self', 'Identification and belonging', 'Judgement',

and 'Dismissal'. These themes reveal the ambivalence present in patients seeking treatment for gaming addiction, and the factors that positively and negatively contribute to engagement in treatment and experiences of treatment. Patients' belief in the validity and value of their own experience along with experiences of identification and belonging in treatment appear positively correlated with remaining engaged in treatment and having hope about the possibility of effective recovery, whereas patients' expectations or experiences of judgement or dismissal from clinicians appear correlated with fear about treatment outcomes, increased dishonesty in treatment, and lack of engagement with clinicians.

5. Discussion

5.1 Implications

A number of clinical implications arise from this research, some of which have been discussed previously. Perhaps the single greatest implication is that clinicians need to be willing to hear and trust patients' narratives about their own experiences, as clinicians' ability to do this will impact across all of the identified themes. When patients feel heard by clinicians, their belief in themselves will likely be strengthened and they will feel a greater sense of identification with the clinician and belonging in treatment. In turn, this is likely to improve their overall hope about the possibility of positive treatment outcomes and engagement in treatment. By contrast, when participants experience dismissal or judgement from clinicians, their belief in self is likely to be lessened and fears may be aroused about the clinician or treatment outcomes.

Participant experiences also suggested that they were more likely to feel accepted and heard by clinicians when the clinicians were able to provide a framework for understanding

participant experiences, and so a further implication of the research is that it will be helpful for clinicians working with gaming addicts to become aware of the existing research and possible models of understanding behavioural addictions. Although some participants found that treatment based on other addictions seemed helpful and relevant to them, several of them still expressed a belief that treatment focused specifically on gaming addiction would have been even more helpful, and suggested that professionals need to learn about this topic. As one participant stated, it was the "nitty gritty" of gaming addiction that she felt unable to talk about and explore with others who did not have this understanding.

One of the main factors in gaming addiction that clinicians may need to be particularly aware of due to its uniqueness to this addiction is the strength of the identification process that can occur particularly for online gamers. As several participants stated, online gaming became their whole social world while they were gaming, and the sense of belonging and being wanted, needed and even idolised in this world was a powerful motivator for playing. In some cases, participants spoke about leading a 'double life' or seeing themselves as two separate identities, one in the real world and one in the game world. Clinicians therefore need to be aware that for a gaming addict contemplating giving up gaming this could mean the effective destruction of this virtual self, an identity that may have been highly valued and cherished. Clinicians will need to be prepared to explore the meaning of this with patients, and help them accept and process what may be experienced as a very real loss of self.

Clinicians may also need to be aware of prevailing social attitudes and beliefs about gaming and gaming addiction, as stigma and shame associated with gaming in the wider community may also contribute to patients being reluctant to discuss the extent and impact of their gaming with a professional. In cultural contexts in which gaming and particularly excessive gaming are seen as shameful, clinicians may need to work hard to create a treatment

environment in which patients do not feel judged and feel safe enough to discuss their experiences meaningfully.

5.2 Limitations

There are a number of limitations to this research that should be addressed. The most significant of these relates to the small sample size used in the research. Although there was some significant similarity between participant perspectives, these perspectives were also quite divergent at times, and so it is not possible to determine from this research whether these findings could be generalised outside of this study. Further, the fact that the participants were recruited from different countries creates limitations for this research. The nature of available treatment varied from country to country, and so participant experiences may have been very different for this reason alone. In addition, prevailing social attitudes towards gaming and gaming addiction also would have varied from country to country, and as participants identified this as a factor contributing to their expectations for treatment, it is reasonable to assume that this could differ depending on the social context.

Another limitation of the research is that I, as the researcher, have had first-hand experience with the topic under investigation, and so it is likely that this will have affected the way in which I interpreted the data based on my own experiences. I have attempted to minimise this through being as transparent as possible about my processes, yet it is not feasible to eliminate this factor altogether.

5.3 Recommendations for Further Research

This is one of the first pieces of research to examine the experiences of gaming addicts who have received treatment, and could be considered a pilot study in this area. Further research is certainly required, and ideally such research will include a larger sample size, and could further investigate the validity of the findings of his research by using the identified themes as a starting point for exploring patient experiences in greater depth.

It could also be valuable to conduct research within more homogenous populations, and within more consistent treatment settings. For example, future research could explore and contrast patient experiences of treatment within residential treatment settings to that of patients in outpatient treatment. Similarly, comparisons could be made between individual and group treatment, and between online and in-person treatment.

Future research could also explore possible links between experiences of treatment and identified motivations for gaming. A number of researchers have begun to address the underlying psychological factors that contribute to gaming and internet addiction (Gentile et al, 2009; Shorrock, 2012), and further research could explore possible correlations between a patient's primary motivations for gaming and their experiences of treatment. For example, it might be that gamers who play primarily in order to experience a sense of social inclusion and belonging would experience group treatment more positively than those who had played games in order to experience a sense of potency and achievement.

Lastly, future research could also explore patient experiences of treatment as provided by clinicians with different training backgrounds and areas of expertise, or by clinicians practicing different modalities of treatment. As noted previously, only a limited number of therapeutic modalities have been studied in relation to this client group, and so research

exploring experiences within other modalities would add to clinical knowledge of working with this population.

5.4 Conclusion

Using semi-structured interviewing and thematic analysis, this research investigated the experiences of treatment of four participants who self-identified as experiencing problematic gaming or gaming addiction. Participants had received treatment in a variety of settings, including residential in-patient treatment, group therapy and individual counselling. A significant amount of diversity existed between participant perspectives, however, several major themes emerged consistently between interviews. Participant perspectives and experiences of treatment could be broadly grouped under the global themes of 'Hope' and 'Fear', which represented opposing forces influencing patients' desire, or lack of desire, to engage with treatment.

Patients' hope was largely associated with patients' belief in the validity and truth of their own experiences, particularly when faced with dismissal or judgement by clinicians, as well as by belief in their own capacity to heal and change their own lives. Hope was also associated with patients' experiencing a sense of identification and belonging in treatment, whether with the clinician or with others patients who were overcoming similar problems of addiction.

Conversely, fear was largely associated with patients' negative experiences or expectations about treatment and clinicians. Negative experiences could be separated broadly into two types of experience. The first of these, judgement, reflected patient experiences and expectations of being condemned, pitied, or otherwise evaluated negatively by clinicians.

The second, dismissal, reflected patient experiences and expectations of being disregarded by clinicians, or of not being taken seriously. Both judgement and dismissal were common experiences described by patients, and led to disillusionment and disengagement from treatment when they occurred.

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Appendix One – Participant Consent Form

Consent Form

For use when interviews are involved.

Project title: ***Problem gamers' perceptions and experiences of therapy***

Project Supervisor: ***Dr Stephen Appel***

Researcher: ***James Driver***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 26 August 2013
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (*please tick one*): Yes○ No○

Participant's signature: ……

Participant's name: ……

Participant's contact details (if appropriate):

……..

……..

……..

……..

Date: _____

Note: The Participant should retain a copy of this form.

Appendix Two – Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

26 August 2013

Project Title

Problem gamers' perceptions and experiences of therapy

An Invitation

You are invited to take part in a research project exploring the experiences of people who have talked about problematic online gaming behaviours with a mental health professional. My name is James Driver and I am a psychotherapist undertaking this research study for my Master's dissertation. Your participation in this project is entirely voluntary, and, should you choose to participate you may also choose to withdraw your participation at any time during the process. You will not be identified in any writing up of the findings.

What is the purpose of this research?

Very little research exists within New Zealand or internationally about what methods are helpful for reducing problematic behaviours around online gaming, yet there is plenty of anecdotal evidence that suggests that conventional therapeutic approaches may be beneficial. This research aims to develop an understanding of what people with problematic gaming behaviours have experienced as helpful or unhelpful, in order to guide mental health professionals in working with this issue in the future.

How was I identified and why am I being invited to participate in this research?

You are being invited to participate in this research as you have responded to a general invitation issued via an online forum, or an advertisement posted You may also have been identified by word of mouth by someone who knew about the study or had participated and thought you might be interested. You are eligible for taking part in the study if you have:

a) Now or in the past experienced problems with your online gaming such as playing more than you would like, neglecting other activities in order to play games etc. And

b) Discussed these problems with a mental health professional in a therapeutic context, such as in counselling or therapy

You cannot take part in this study if you are still visiting the same therapist or counsellor referred to in b) above.

What will happen in this research?

The study involves interviews with participants that will take place via online voice chat – Skype, Ventrilo or Mumble. These interviews will be digitally recorded. If you choose to take part, you will be asked to spend between 60 and 90 minutes being interviewed about your experiences of discussing problematic online gaming with a mental health professional, at a time that is convenient for you. You may choose to discontinue your participation at any time.

What are the discomforts and risks?

Problematic behaviours and addictions are often personal and delicate subjects to discuss. You may experience a degree of vulnerability when discussing this topic.

How will these discomforts and risks be alleviated?

You may choose to have the recorder turned off at any point during the interview and withdraw from the interview/research process at any time. If you experience distress, you will also be referred to the support groups available through olganon.org, or to free counselling services available in your country. This will allow you to receive support for any concerns you have arising from participating in the research.

What are the benefits?

Participating in this research will provide you an opportunity to reflect on your experiences with problematic online gaming. This may contribute to a deeper understanding of your past experiences and behaviours, and may contribute to a greater sense of clarity around how you wish to engage with gaming, technology and the internet in future. The research will also benefit mental health professional who will be better equipped to understand the concerns of those experiencing problematic online gaming, and will have a deeper awareness of what interventions and approaches are experienced as helpful. I will also benefit from the research as it will add to my understanding as a psychotherapist and I will obtain a Master's degree at the completion of the study.

How will my privacy be protected?

Your digitally recorded interview will be transcribed only by me. Your identity will be kept confidential by the use of a pseudonym and any potentially identifying information will be excluded from the final report and any verbal presentations of the material. However, given the small size of the pool of participants it may only be possible to offer limited confidentiality. Identifying demographics with participant identification numbers will be stored separately from the research data, as will signed consent forms. All material involved in the research will be secured in a locked filing cabinet and destroyed after six years.

What are the costs of participating in this research?

The only cost involved in you participating in this research is your time. As indicated earlier, if you choose to take part, this will involve an interview of up to 90 minutes. Costs incurred from participating will be reimbursed at a fixed rate of $30 NZD per participant.

What opportunity do I have to consider this invitation?

I would find it helpful if you could let me know within a month whether or not you wish to participate.

How do I agree to participate in this research?

You will need to complete the consent form included with the Participant Information Sheet to participate in this research. Please return the completed form to the Project Supervisor Dr Stephen Appel at AUT University, Private Bag 92006, Auckland 1142, New Zealand.

Will I receive feedback on the results of this research?

I will post or e-mail you a copy of the summary of the research findings if you would like to receive this information. This could be between 1-3 years after you are interviewed depending at which stage of the research you are interviewed.

In addition, you will receive a copy of the transcript of the interview which includes both the researcher's questions and your responses. You will have the opportunity to provide feedback based on the transcript to the researcher if you wish to do so.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Stephen Appel, stephen.appel@aut.ac.nz ph. +64 9 921 9999 ext. 7199

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , +64 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details: James Driver, 46 Parklands Drive, Huntsbury, Christchurch 8022. Ph. +64 20 40000 103. james@counterweight.co.nz

Project Supervisor Contact Details: Dr Stephen Appel, stephen.appel@aut.ac.nz ph. +64 9 921 9999 ext. 7199

Approved by the Auckland University of Technology Ethics Committee on *10 July 2013*, AUTEC Reference number *13/126*

Appendix Three – Recruitment Flyer

RESEARCH RECRUITMENT

Have you had problems with online gaming addiction or overuse?

I'm doing research to help understand what is helpful and unhelpful for people who have had problems with overuse or addiction to online computer / console gaming.

If you:

a) **Have had or still have problems with online gaming such as playing more than you would like or neglecting other activities in order to play games, and**

b) **Have talked about this at some point with a mental health professional (counselor, therapist, psychiatrist, University health advisor)**

Then I would like to invite you to take part in an interview-based research project .

Contact me at james@counterweight.co.nz and I will send you full details of the research.

Your participation is entirely voluntary, all personal details will be kept confidential, and you have the right to withdraw from the research at any time. Travel costs if any will be reimbursed in the form of a petrol voucher.

Appendix Four – Online Forum Recruitment Posting

Online Forum Recruitment Posting

Title: Recruiting for research interviews with people who have received counselling for problematic gaming

I'm looking to recruit participants who would like to take part in research designed to help understand what types of therapy and counselling are helpful for problematic or addictive gaming.

If you:

a) Have had or still have problems with online gaming such as playing more than you would like or neglecting other activities in order to play games, and

b) Have talked about this at some point with a mental health professional (counselor, therapist, psychiatrist, University health advisor)

Then I'd very much like to speak with you if you would be willing to take part in an interview.

I'm a master's researcher at AUT University in Auckland, New Zealand, and am working on a dissertation to try and add to our understanding of how therapists and counsellors can best work with people who have experienced problems with their gaming. As many of you are probably aware, there's a relatively small amount of research around the topic of gaming addiction, and even less around treatment, and so my hope is that this research will help build on what is known already and in the long run, improve treatment outcomes for people struggling with gaming.

If you'd be interested in finding out more about taking part, please message me here on the forums or email me at james@counterweight.co.nz and I will send you a participant information sheet which explains more about the research and what would be involved. In short though, taking part would mean having an interview of around 90 minutes via voice chat (probably Skype) about your experiences of talking with a therapist or counsellor about gaming. All information collected during the research will be confidential, and personal details will be anonymised during the write-up.

Appendix Five – Researcher Safety Protocol

Researcher Safety Protocol

Since some of the interviews conducted for this study may take place in participant's homes, the following researcher safety plan has been designed to minimise any potential risk to the researcher.

1) Once an interview time has been agreed with a participant, and if it is not in a public place, then:
    a) the researcher will advise a colleague of the date and time of this interview ahead of it occurring, and will ensure that the colleague is available and willing for the researcher to check in with him/her before and after the interview takes place.
    b) a few minutes before the interview begins on the day of the interview, the researcher will contact the agreed colleague by text message or phone call and advise him or her that the researcher is entering the participants' home.
    c) upon completion of the interview, the researcher will again contact the colleague and advise him or her that the researcher has left the participants' home, and has no safety concerns.
    d) in the unlikely event that the researcher does not make contact with the colleague at the appointed time, the colleague will in the first instance attempt to contact the researcher on the researcher's mobile phone. If the colleague receives no answer, he or she will attempt to contact the researcher on a second mobile phone that the researcher will have with him.
    e) If the colleague is unable to establish contact through either means, then he or she will alert the appropriate authorities to investigate further, most likely the police

As the researcher is an employee at Stopping Violence Services Christchurch (SVS), it is likely that the colleague who will maintain contact with the researcher before and after the interview will be a co-worker from this agency.

Additionally, the researcher will take all necessary steps to understand and respect the cultural and social values of participants while visiting their homes, and will ask for clarification if unsure. The researcher's training in psychotherapy will also likely contribute to his ability to assess the safety of any situation, and to manage aggressive or confrontational behaviour from participants in the unlikely event that this occurs.

Appendix Six – Indicative Research Questions

Indicative Questions

For use when interviews are involved.

Project title: ***Problem gamers' perceptions and experiences of therapy***

Project Supervisor: ***Dr Stephen Appel***

Researcher: ***James Driver***

The following are indicative of the types of questions that may be asked of participants during the interviews for this research.

1. Can you tell me about the sorts of games you enjoy playing
2. Can you tell me a bit about when and where you would usually play games
3. Can you tell me about the time when you first felt that gaming might be a problem for you
4. Can you tell me about how you ended up seeing your counsellor/therapist for the first time?
5. Can you describe the first time you brought up the issue of gaming with your counsellor/therapist?
6. Can you describe what you thought about and how you felt before bringing the topic up with your counsellor/therapist?
7. How was it for you to talk about gaming with your counsellor/therapist?
8. Can you tell me of a time when your counsellor/therapist talked with you directly about your gaming?
9. Can you tell me about something your therapist/counsellor did with you that you found helpful/unhelpful?

Appendix Seven – AUTEC Approval Letter

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

AUTEC SECRETARIAT

10 July 2013

Steve Appel
Faculty of Health and Environmental Sciences

Dear Steve

Re Ethics Application: **13/126 Problem gamers' perceptions and experiences of therapy.**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 10 July 2016.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online throughhttp://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 10 July 2016;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 10 July 2016 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: James Driver james@counterweight.co.nz

Appendix Eight – AUTEC Approval Letter Variation

A U T E C
S E C R E T A R I A T

27 August 2013

Steve Appel
Faculty of Health and Environmental Sciences

Dear Steve

Re: Ethics Application: **13/126 Problem gamers' perceptions and experiences of therapy.**

Thank you for your request for approval of an amendment to your ethics application.

I have approved the minor amendment to your ethics application allowing recruitment internationally using an online forum.

I remind you that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 10 July 2016;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 10 July 2016 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

James Driver james@counterweight.co.nz