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FULL-LENGTH REPORT

Personal experiences of suicidality in women with gambling disorder – A qualitative interview study

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ABSTRACT

Background: Gambling disorder is associated with increased suicidality, especially in women who also are more likely to have psychiatric comorbid disorders and more often have experiences of traumatic life events. Although suicidality is increased and several risk factors have been identified, knowledge of the suicidal process is lacking, especially for women. *Aim:* To explore the lived experiences of suicidality in women with gambling disorder and to investigate potential factors involved in the development of suicidality. *Method:* Semi-structured interviews were held with seven women with experiences of gambling disorder and suicidality in Malmö, Sweden between November 2021 and June 2022, when saturation was reached. Interviews were audio-recorded, transcribed, and coded in NVivo. Qualitative content analysis was used to build categories and themes. *Results:* Several women had experienced suicidality before developing gambling disorder and gambling-related suicidality. However, for some, suicidality had appeared seemingly only due to the gambling disorder. Suicidality ranged from ideation to severe suicide attempts. Three themes of factors modulating suicidality related to gambling were found; a) guilt shame and self-stigmatization, b) loss of control/chaotic life circumstances, and c) social consequences/fear of guilt and shame from others. *Conclusion:* More research on the experience of suicidality in women with gambling disorder is needed. Attempts to address self-stigmatization, guilt, and shame in women with gambling disorder and society at large as well as aiding women to regain a sense of control over their economy and gambling may be ways to reduce suicidality.

KEYWORDS

gambling disorder, women, suicidality, stigma, guilt, indebtedness

INTRODUCTION

Gambling disorder (GD) is an addictive disorder often associated with psychiatric comorbidity, suicidality and increased general and suicide mortality (Håkansson & Karlsson, 2020; Karlsson & Håkansson, 2018; Sundqvist & Wennberg, 2021). However, knowledge on suicide mortality and the suicidal process is severely lacking, particularly among women with GD. Indeed, increased suicidality is seen in a spectrum of individuals with loss of control of their gambling and problem gambling has been estimated to be an independent risk factor for suicidality (Wardle, John, Dymond, & McManus, 2020). In fact, it appears as if the increase in gambling related difficulties appear to increase the risk of suicide attempts rather than the level of problem gambling itself (Wardle, Kesaite, Tipping, & McManus, 2023).

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Women with GD tend to suffer from greater psychiatric comorbidity such as anxiety and depressive disorders (Håkansson, Karlsson, & Widinghoff, 2018; Larsson & Håkansson, 2022; Newman & Thompson, 2007). Suicidal thoughts, suicide attempts, and self-harm are also more common in women with GD (Bischof et al., 2015; Håkansson & Karlsson, 2020; Karlsson, Hedén, Hansson, Sandgren, & Håkansson, 2021). It also appears that women are more likely to develop GD secondary to prior psychiatric comorbidity[11], are older when they develop GD and gamble more frequently as a result of negative emotions (Grant, Chamberlain, Schreiber, & Odlaug, 2012) or traumatic life events such as being the victim of intimate partner violence (Hing et al., 2022). Further, women are more likely to have family members with GD as well as alcohol use disorder (Grant et al., 2012). In the pathways model, Blaszczynski and Nower propose three different pathways to GD in which one group develops GD secondary to psychiatric comorbidity, a second group develops GD without prior vulnerability, and a third group develops GD due to a proclivity for kick-seeking and impulsivity, with the two latter groups potentially suffering psychiatric comorbidity as a result of their GD (A. Blaszczynski & Nower, 2002). Women may be more likely to follow the first path.

Women with GD appear to be more socioeconomically vulnerable (Larsson & Håkansson, 2022), more likely to receive social welfare payments, more likely to be divorced (Karlsson et al., 2021), and possibly more vulnerable to over-indebtedness (Håkansson & Widinghoff, 2020).

Over-indebtedness implies a loss of control of one's own financial situation and is associated with a more severe GD (Håkansson & Widinghoff, 2020; Oksanen, Savolainen, Sirola, & Kaakinen, 2018). In Sweden, the Enforcement Authority has the authority to decide whether an individual should be subject to "debt enforcement" if they have not repaid a debt (Kronofogden, 2022). This implies that the Enforcement Authority can decide to deduct money from the indebted individual's salary (or other forms of income such as sickness or parental benefit or pension) or by selling the possessions of the indebted individual (Kronofogden, 2022). A recent case-control study investigating suicide mortality among those registered as owing money with the Enforcement Authority found an increased risk of suicide when psychiatric and socioeconomic factors were analysed (Kronofogden, 2022). In line with this a qualitative study using a hermeneutic phenomenological design from South Chorea indicated that women gambled to escape loneliness and that guilt and shame were consequences of economic loss (Kim, Kim, & Dickerson, 2016).

Although the percentage of women with GD might be increasing, GD is more prevalent in men and previous research has been inconclusive with regards to suicide mortality in women with GD (Håkansson et al., 2018; Karlsson & Håkansson, 2018, 2023). An Australian study examining why young women tend to gamble more frequently than previously found that feminization of commercials, gambling as a family activity – often with their fathers, and gambling as a social event might explain this increase (McCarthy, Thomas, Pitt, Daube, & Cassidy, 2020). Despite this feminization, women with GD often experience stigmatization (Dąbrowska & Wieczorek, 2020, 2021; Quigley, 2022). This fear of stigmatization also appears to be a barrier to seeking treatment (Dąbrowska & Wieczorek, 2020, 2021), and might affect suicidality.

Altogether, on a group level, women with GD appear burdened by several vulnerable factors including psychiatric comorbidity, socioeconomic difficulties, stigmatization, and suicidality. As quantitative research has shown conflicting results with regards to suicide levels in women and knowledge on pathways to suicidality is greatly lacking, qualitative research is needed on the subject. A recently published systematic review of qualitative studies found unmanageable indebtedness and shame to be the most common links between problematic gambling and suicidality in the twenty studies investigated (Marionneau & Nikkinen, 2022). Indeed, this relationship between gambling, guilt and the shame associated with the economic consequences might thus reinforce gambling as well as its related suicidality in women (Kim et al., 2016; Marionneau & Nikkinen, 2022). However, the authors concluded that the field lacks knowledge of other potential gender differences with regard to gambling-related suicidality (Marionneau & Nikkinen, 2022). The suicidal process is important to understand not only due to the pain it causes the affected individuals and also their loved ones but also since suicidal thoughts (Owens, Horrocks, & House, 2002), non-lethal suicide attempts (Hubers et al., 2018), and non-lethal self-harm (Hubers et al., 2018), increase the risk of suicide death in general.

Aim: This project aims to explore the lived experiences of suicidality in women with GD. And to investigate potential factors involved in the development of suicidality.

Research questions: What are the personal experiences of suicidality in women with GD? What are these women's life experiences?

METHODOLOGY

This is a semi-structured interview study that has been analysed using qualitative content analysis. Due to the delicate nature of the research, we concluded that face-to-face interviews would be the safest way to investigate suicidality as it offers a possibility to assess acute suicidality and hopefully prevent suicidal actions. A semi-structured interview guide offered opportunities to follow the stories told by the women in a more flexible way, aiding in forming alliance. Also, it allows for modification to ensure richer data as well as offering a possibility to evaluate the interview guide – should any set of question prove to evoke negative reactions. Qualitative content analysis was hereafter chosen since it is a flexible and theoretically rather free methodology in our opinion suitable for this research field as little is previously known about the suicidal process in women with GD (Braun & Clarke, 2006; Graneheim & Lundman, 2004). In line with this an inductive approach was utilized through

systematically searching for patterns and similarities in different parts of the interviews as well as across interviews (Braun & Clarke, 2006; Bryman & Nilsson, 2011).

Context

The study was undertaken in the Swedish town of Malmö in the Region of Skåne, Sweden. Malmö is a town of some 350,000 inhabitants with a majority of ethnically Swedish individuals with one-third born abroad (Malmö Stad, 2022). In Malmö there are three main centres for support of individuals with GD:

1. "Spelberoendes förening, Malmö (Spelberoendes förening Malmö, 2022)" (a patient organization for individuals with GD in Malmö), offering support groups for individuals with GD,
2. the treatment centre "Öppenvårdsmottagningen Gustav (Region Skåne (a), 2022), an outpatient treatment centre for addictive disorders, including GD, under the communal social services, and
3. the outpatient GD-treatment facility situated in the town of Malmö which forms a part of public health care in the region of Skåne, "Triangelmottagningen (Region Skåne (b), 2022)".

Recruitment process

Criterion sampling was utilised (Moser & Korstjens, 2018). The inclusion criteria for the study were as follows:

- Identifying as a woman
- Having a GD
- Having experienced suicidality (thoughts and/or actions)
- Being enrolled at the Triangelmottagningen, Öppenvårdsmottagningen Gustav or Spelberoendes förening.

All four criteria needed to be met for the individual to be included in the study.

Posters were hung on the walls of the recruitment centres. In the two treatment centres, author Anna Karlsson (AK) informed the therapists at the treatment centres and handed out information and consent brochures. At the patient organization, AK instead informed the regional head of the organization and handed out information folders as well as partook in a digital meeting to inform participants of the organization about the study. Interested individuals contacted their therapist who directed them to AK or they were able to contact AK by using the contact information on the folders or posters.

Inclusion was ongoing until the material was considered saturated (and individuals were recruited between November 2021 and mid-June 2022).

Interview guide: A pilot interview guide in Swedish, was constructed by the three authors based on the research questions. Following the first interview, a discussion between the authors on the need to penetrate suicidal experiences further lead to adjustments in the guide to focus more on suicidal experiences, this was then used for the remaining interviews and can be found the supplementary material. We aimed to utilize inclusive language in the interviews and to avoid stigmatizing concepts (Alex Blaszczynski, Swanton, & Gainsbury, 2020).

Interviews

Interviews took place in the regional outpatient clinic "Triangelmottagningen" in Malmö and were held and transcribed by AK. AK had undertaken a university class in qualitative methodology and had support from supervisors Anders Håkansson (AH) and Helena Hansson (HH) (who is experienced in qualitative methodology). AK had only had brief contact with the study participants prior to the interviews (telephone $n = 5$ and email $n = 2$ to ensure willingness to partake in the interview and answer potential questions about the study). The aim was to keep the interviews at around one hour to one hour thirty minutes, and to not exceed two hours. Interviews were audio-recorded and transcribed verbatim in a Microsoft Word document.

Analysis and preunderstanding: After transcribing the interviews in Microsoft Word, these along with the audio uptakes were uploaded to the qualitative analysis software program NVivo version 1.6.1 which was used to analyse the material. Qualitative content analysis was the method used for context analysis.

In NVivo, stop words in Swedish were used to exclude non-important words from the analysis such as, and, mmm, hmm, and so forth. A word cloud was synthesized to give a picture of the raw data in the material.

AK, who is a medical doctor and PhD student in addictive disorders, focusing on the negative consequences of GD, coded the material into small unit codes in NVivo. The material was discussed with her supervisors, psychiatrist and professor in GD, Anders Håkansson (AH), and assistant professor in social work Helena Hansson (HH) with experience in qualitative methodology and addiction research. AK, AH and HH then together constructed themes based on codes and interpretations of the written interviews. To ensure accuracy, HH also listened through the audio files. In collaboration AK, AH and HH then constructed themes based on the categories developed from the interviews in line with a qualitative content analysis as suggested by Graneheim and Lundman (Graneheim & Lundman, 2004). Based on the experiences shared in the interviews, we created themes of mediating factors in the development of suicidality. These themes were unique to the related experiences and did not constitute an all-encompassing explanation of suicidality. Several themes are present for some women. In creating codes, themes and categories, the authors AK, AH and HH tried to keep an open mind, but a certain level of preconceptions was present which is likely to have influenced the analysis and interviews. These preunderstandings were based on experiences of treating individuals with GD (AH), previous research on GD-related suicidality (AK, AH and HH) and research on suicidality in general (AH, HH). These preconceptions were discussed openly and involved most importantly a belief that monetary effects and indebtedness as well as psychiatric comorbidity, social

isolation, lies, relational difficulties as well as previous life traumas would be common and of importance for suicidality among the women.

The authors evaluated the data, through continuous reading and discussing each interview, recurring patterns in and across interviews. Differences started diminishing after the three first interviews and in the two last interviews only categories similar to previous ones were identified resulting in the decision to close inclusion to the study.

Results were presented without linking each citation to a specific study to increase the anonymity of the study persons.

Figure 1 gives a brief outline of the workflow in conducting and analysing the interviews as well as determining saturation.

Ethical consideration: GD is associated with stigmatization (Palmer, Richardson, Heesacker, & DePue, 2018), and women might be more prone to experience stigmatization (Dąbrowska & Wieczorek, 2020, 2021; Quigley, 2022) being in the minority among those with GD. Further, experiences of suicidality can be a sensitive subject that can evoke thoughts and emotions that need immediate attention. Our goal was to meet these women with a professional and empathic attitude, as well as to carefully inform the women about the topic of the interview so that those who felt it would be too much could decline participation in advance. Individuals were informed that they could withdraw their consent at any time and that they could interrupt or leave the interview at any time. The interviews were conducted at a psychiatric outpatient clinic with psychiatric nurses and a psychiatrist close by, in case the interviewee should need immediate attention. Further, interviews were held by a medical doctor with experience in suicide risk assessment and GD research focused on suicidality.

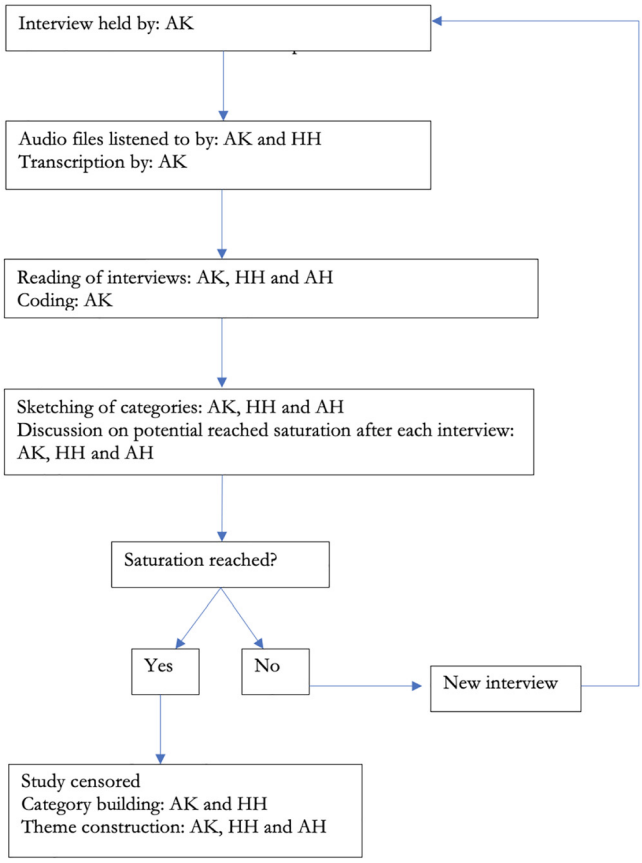

Fig. 1. Depicting the workflow in interviewing, analysing the content, and determining saturation. (AK = Anna Karlsson, HH = Helena Hansson, AH = Anders Håkansson)

The research was funded by the Swedish Southern Health Care Region and AB Svenska Spel, the Swedish state-owned gambling operator as part of the latter's responsibility for gambling and research policy. Gambling providers including AB Svenska Spel have previously been criticised for laying responsibility on the gambler for the harms she has suffered in relation to her gambling, not taking account for the responsibilities of the gambling provider (Alexius, 2017). As several factors regarding gambling availability, as well as the design of the games are known to impact the development of GD (Sulkunen et al., 2021), it is our belief that the decisions of gambling providers and policy makers are of great importance in terms of developing GD and its related harms. AB Svenska Spel has since made attempts to address their responsibility towards gamblers who experience harms, for example by evaluating motivational telephone interventions to high-risk gamblers (Håkansson, Franklin, Dahlström, & Lyckberg, 2022).

As AB Svenska Spel has an independent research committee of members not otherwise involved in the company who oversee the grants we have concluded that it would be more ethical to perform the research – made possible by the grant rather than to not do so. We have previously conducted research indicating elevated suicide and mortality levels in GD (Karlsson & Håkansson, 2018), yet continued to receive grants from AB Svenska Spel and have perceived a freedom from expectations from the grant holder. None of the funders have had insight into the research process nor have they approved nor read the manuscript prior to publication.

Compensation: Study participants received a gift card of 500 SEK (53 USD) from a major shopping mall in the centre of Malmö, "Triangeln", in which groceries, clothing, home décor, electronics and more could be purchased, but without an opportunity to gamble. Within a few days, the compensation was issued. Compensation was decided upon through a discussion with the Nordic gambling network "Gambling Research Network" (GARN), it aimed to provide fair compensation for the time and emotional effort from the study participant without giving too much of an economic incentive nor enabling further gambling (Stockholm University, 2022).

Ethics

Oral and written consent was obtained. The study was approved by the Swedish Ethical Review Authority (Ethical approval number: 2021-02747) and conducted in accordance with the Declaration of Helsinki.

RESULTS

Results were presented according to the COREQ-checklist for qualitative interview studies (Tong, Sainsbury, & Craig, 2007).

Seven interviews were held between November 2021 and June 2022. Two women were initially interested in participating but considered themselves to be too mentally unstable to manage the interview as they were going through major life crises. Interviews varied between 63 and 79 min in length and resulted in a total of 65,972 words.

Sample

All participants were Swedish speakers but with varied ethnicities from different European regions. The women came from different socioeconomic backgrounds and had different sexual orientations. All of the interviews indicated that the women qualified for a GD diagnosis according to the DMS 5 manual (American Psychiatric Association, 2013). Table 1 describes some background characteristics of the sample.

All women described experiences of suicidality ranging from suicidal thoughts to severe life-threatening attempts requiring intensive care. Some had experiences of suicidality solely due to consequences of their GD and some had previous suicide attempts due to mental health disorders and life events before developing GD. All but one experienced suicidality in relation to the negative consequences of their GD.

One woman described suicidality as well as self-injurious behaviour in relation to her GD. The majority of the women gambled at least partially to escape negative emotions and one woman did not experience suicidality due to her GD, instead gambled to escape negative emotions and suicidality caused by traumatic life events. However, for this woman, the consequences of her indebtedness led to difficulties with the Enforcement Authority which she hypothesized would increase her suicidality. Indeed, several women described gambling as providing temporary relief from negative emotions, however, with increased negative emotions shortly after or during the gambling session.

Many of the women had experienced traumatic life events during childhood and adult life. Although a few individuals described a happy and non-traumatic upbringing and life before developing GD. Depression, anxiety, and potential bipolar disorders (though not diagnosed) as well as alcohol and substance use disorders were mentioned by women who had previously experienced mental health disorders.

Several women brought up experiences of feeling stigmatized as women with GD. Some had been the only woman in group therapy, experiencing that the male group members did not quite include them in the group. Some had even experienced male therapy group members to have asked them out on dates, which made them want to quit therapy. Three of the women asked about how the other

Table 1. Depicting background information on the sample. ($N = 7$)

Recruitment from:	
Regional health care center[1]	4
Social services treatment center[2]	3
Patient organization[3]	0*
Age	
20–40	3
41–65	3
>65**	1
In a relationship	4
Having children	4
Education level:	
Elementary school (9 years)	1
Upper secondary school (12 years)	3
University	2
Unknown	1
Current employment status:	
Employed (and for some part-time sick leave)	3
Unemployed and/or full-time sick leave	3
Retired	1
Self-reported psychiatric comorbidity	5
Parents with mental health disorders	4
Witnessing or experiencing sexual or physical abuse growing up	3
Gambling culture in the family growing up	4
Victims of intimate partner violence or sexual harassment as grown-ups	3
Gambling form:	
Slot machines	3
Online casino	7
Online roulette	1
Offline casino	2
Online poker	2
Offline poker	3
Sports betting	1
Lottery	0
Bingo	2
Economic consequences:	
Over-indebtedness	7
Debt enforcement by the Enforcement Authority	1
Awaiting a decision from the Enforcement Authority	3
Fearing involvement by the Enforcement Authority	1
Borrowing from friends and family	5
Committing illegal acts	2
Previous suicide attempts	4
Gambling disorder-related suicidality:	6
Ideation (thoughts or planning)	6
Attempts	2

[1]Triangelmottagningen. [2]Öppenvårdsmottagningen Gustav. [3]Spelberoendes förening, Malmö. * No women were recruited from the local patient organization "Spelbeorendes förening Malmö" and the head of the organization explained that no women with GD were active there during the period. **65 years of age is the typical retirement age in Sweden.

members of the study had ended up in this position. Two women brought up the lack of women in the public speaking out about GD – something they had never seen, making them feel alone. Most of the women felt more secure and were very pleased with having a therapist they knew at "Triangelmottagningen" or at "Öppenvårdsmottagningen Gustav" which they described as preventive of a relapse and protective regarding their suicidality. Some women wondered whether they would still be alive, or how they would have coped without their therapist.

Non-gambling-related experiences of suicidality

Several women also had non-gambling-related experiences of suicidality. These experiences were diverse and took different expressions. Some of the women had previous experiences of suicidality before they became addicted to gambling, or concurrent with their GD, but in their experience not related to it.

One woman described making several suicide attempts through prescribed drug intoxication after experiencing intimate partner violence. "And then I was beaten up. It was hell back then. And if you're beaten by another adult and being told you can't do anything – you can never make it without me, you're worthless and all sorts of things. Then, in the end, you start believing it, and so I attempted one suicide after another".

One woman described a death wish and increased gambling and drug problems after being sexually harassed at work "Now I want to die. Now I want to die. My career is over. What I had, which was so important in my life is slipping away from me. Then I disappeared into gambling and drugs". Describing how suicidality increased her gambling which was seen as an escape from negative emotions.

One woman described a suicide attempt in her childhood where she jumped off a bridge after her mother abandoned her. Another woman described suicide attempts by attempting to hang herself, once in relation to a separation from a previous partner and once during alcohol intoxication during her previously active alcohol addiction.

Experiences of suicidality related to gambling disorder and mediating factors

Six of the seven women described suicidality directly related to their gambling disorder and the following themes are derived from those six interviews. In our coding, category, and theme building, a model with three different themes was constructed as presented below focusing on the factors involved in mediating suicidality related to GD. Themes with belonging categories can be found in Table 2.

Table 2. Themes and mediating factors in the development of suicidality

Theme	Category
Guilt, shame, and self-stigmatization	The shame of not being able to repay debt
	Guilt and shame related to financial situation
	The feeling of being a burden
	The shame of lying to or stealing from others
	Disgust with oneself
	Guilt and shame of not being able to control oneself/continued gambling
	The feeling of failure
Loss of control/chaotic life circumstances	Fear of homelessness or unstable living conditions
	Afraid of criminal vindication
	The fear of economic consequences
	Not being able to control chaotic gambling
	The fear of being enrolled within the Enforcement Authority
Social consequences/ fear of guilt and shame from others	The feeling of not fitting in (Instagram life)
	The fear of being outed by family/ friends/work – expecting or receiving a negative reaction
	The feeling that you have broken your expectations as a woman through gambling
	Not being or feeling accepted

Guilt, shame, and self-stigmatization mediating suicidality

Several women described a pattern stemming from the shame and guilt of gambling or from the consequences of the gambling such as lies, financial difficulties and stealing from others. This shame and guilt seemed to lead to a suicidal process in some of the women, see Table 3.

Loss of control/chaotic life circumstances mediating suicidality

Several of the women had experienced suicidality as a result of chaotic times in their lives where the consequences of their gambling evoked suicidality or a sense of loss of control over the gambling itself, thereby mediating suicidality, Table 4.

Social consequences/fear of guilt and shame from others mediating suicidality

Feelings of not fitting in, being invalidated, or feeling offended because of other people's reactions to the gambling appeared to lead to suicidality in some women, Table 5.

Two of the women described experiences fitting in only with the theme of "Guilt, shame, and self-stigmatization mediating suicidality". One woman described experiences fitting in only with the theme "Social consequences/fear of guilt and shame from others mediating suicidality" and three women had experiences from all three themes. One woman described no suicidality related to GD but rather she gambled to escape negative emotions and suicidality related to traumatic life events. Using gambling to temporarily avoid negative emotions was described by all study

Table 3. Examples of guilt and shame mediating suicidality with belonging categories

Context and citations	Category
Disgust with oneself and shame were common. "Well, you lie so much to yourself. It's the lies… And afterwards, you feel so disgusted with yourself. What's the point of life? What do I have? Anything positive?" The same woman also later describes guilt from unlawfully gambling away money from someone in her inner circle. "You manipulate: 'the tax authority took the money before I could repay them'"/…/"The Enforcement Authority took them, and so on…"/…/"It feels so horrible - it is horrible. I turned myself into the police after that. The shame that I felt in my entire body…"	Disgust with oneself The shame of lying to or stealing from others
"One feels terrible… and then, well… disgusted… and the lies that one has pulled…" Another woman explained the lies she told to hide her gambling.	The shame of lying to or stealing from others
Some described feelings of being a burden to others. "That feeling of being totally worthless… You create… problems and pain and illbeing in those that you love. You're a burden" A distressed woman explained while crying during the interview, describing feelings of being a burden due to her economic situation (due to gambling debts) as well as the continued gambling itself. She later described: "I've never gone as far as to plan it in detail or done a real attempt. But the thought has struck me a couple of times… at the train station… it would have been easy to just jump and leave it all."	The feeling of being a burden
One woman described while in tears. "I went into my >near one's< (authors rewriting) bank account and gambled away that person's money."/…/"I did not want to live any longer. I wanted to take my life. So, I was admitted to the psychiatric ward, because afterwards, it dawned on me – What have I done!?"/…/You don't want to be a burden to others. But you *are* a burden when you do these things."	The shame of lying to or stealing from others
Another woman described the shame of her indebtedness and financial situation caused by gambling leading up to a suicide attempt from which she barely survived. She described how she was ashamed of herself for losing all her money – because she considered the money to be for her family, thus blaming herself for letting her family down. "In the end, I couldn't repay my debts. That's how bad it was. As I said, that's when I decided. I took all those pills. I collected pills for more than one year. I thought I had calculated it. But I hadn't… evidently".	Guilt and shame of one's financial situation

Table 4. Examples of loss of control and chaotic situations mediating suicidality with belonging categories

Context and citations	Category
"The worst thing was when I was about to be evicted./…/The panic attack that I had… for weeks. I was so sick. I walked around on the streets screaming and crying. I wanted someone to hit me with a car."	Fear of homelessness or unstable living conditions
"I really fear that the Enforcement Authority might come to our home and take the car, TV… everything. Like what you see in 'Luxury Trap' (Tv show, in Swedish: lyxfällan). It would be terrible if it would happen. If it does, then I don't know…"	Fear of being enrolled within the Enforcement Authority
Feelings of not being able to control one's gambling appeared to evoke suicidality in some as a means to regain some sort of control with one woman speaking of a suicide plan as some form of control. "I've been thinking of hanging myself in the garage. Then no one can find me. But I haven't found the rope yet, and as long as I haven't there's no crisis. It would be irrevocable. It would be such bad luck if I wouldn't make it. Taking an overdose - no. It's so hard if you don't make it".	Not being able to control chaotic gambling
After her interview one woman contacted author AK describing increased ill-being on Fridays as this was usually the time the Enforcement Authority would contact her, leaving her with stress and anguish and a sense of impotency over the weekend before she could contact the authority.	Fear of being registered with the Enforcement Authority

participants, but most often with the consequences of increased anxiety or ill-being afterwards.

Experiences of decreased suicidality

Coming clean with near and dear ones appeared – for many to be extremely stressful. However, once done – if they felt that their close ones showed understanding and empathy, the women experienced a sense of relief and appeared to experience decreased suicidality and increased well-being. This was also the case with treatment-seeking, although it was less stressful. Having a point of contact for the GD within the health care and social services appeared to be very beneficial for the women. These contacts were invaluable and, in some cases, an important safety net if increased suicidality occurred. One woman stated, "I don't think I would be alive today if it wasn't for my >therapist at the GD clinic< (authors

Table 5. Examples of social consequences and/or fear of guilt and shame from others mediating suicidality with belonging categories

Context and citations	Category
One woman described suicidality as a way to escape the fear and shame of how her family would react if her gambling and debts were revealed, and she saw suicide as a way to escape the fear and shame of how her family would react. "Get away from it all. I think deep down I wanted to tell my family and seek help. But I was afraid and thought of fleeing or doing something…"	The fear of being found out by family/ friends/work – expecting or receiving a negative reaction
Another woman described a feeling of not knowing whether she wanted to live after having to pretend everything was fine and dandy, experiencing how others were living a seemingly perfect "Instagram life" and she couldn't lie anymore about hers. "And right after I parted from my family, when I couldn't really tell them how bad it really was – I drove home. I parked by the sea and just – No! I don't care about this! I was so indifferent. I don't care. I can't, no more"/…/"I thought, I don't know if I can live anymore. As I've said, the brain is so mystical because I don't, to this day, remember how I made it home from that parking lot by the sea".	The feeling of not fitting in (Instagram life)

rewriting)." Further, many women described their debt situation, in particular the possible involvement of the Enforcement Authority, as mentally stressful which led to increased suicidality, which we interpreted as part of the theme "Loss of control/chaotic life circumstances mediating suicidality". Similarly, the women who had already been under the enforcement of the bailiff experienced relief once the decision was made and the details were brought out into the open. It appeared to be quite distressing not knowing the state of one's finances. Once done, it appeared to be almost a relief to give the Enforcement Authority control of one's finances for some of the women.

DISCUSSION

This study shows that there is a great variety of experiences among women with GD and experiences of suicidality. Previous psychiatric disorders, traumatic life events, and previous suicidality were all exacerbated in some women by the onset of GD, whereas others had stable and, in their opinion, relatively non-problematic lives that had been drastically altered by the GD. Despite their differences, many of the women shared similar experiences of gambling and suicidality. The three different themes describing mediating factors regarding suicidality will be discussed below.

The theme of "guilt, shame, and self-stigmatization mediating to suicidality" might underline the importance of working on norms in society and that GD also affects women. Such changes in attitude can be one way of diminishing this internal guilt and stress. This could also be addressed in therapy to decrease this feeling to increase well-being and possibly prevent suicidality. The notion that self-blaming and shame over one's gambling led to suicidality has previously been suggested as a mediator between gambling and suicidality (Marionneau & Nikkinen, 2022; Oakes, Pols, & Lawn, 2019). Women may be more afraid of the stigma and of experiencing greater condemnation, which has previously been suggested as a barrier to women being open about their gambling problems (Dąbrowska & Wieczorek, 2020).

Insights into how "Loss of control/chaotic life circumstances" may lead to suicidality may be of interest to the Enforcement Authority to improve communication and increase a sense of control for someone who might be subjected to potential foreclosure. This is important knowledge for the Enforcement Authority to perhaps direct individuals with suspected gambling problems towards health care for treatment and support. Indeed, previous research has found that some suicide attempts are motivated by a desire to gain control, while others are motivated by inner turmoil and a loss of control (Pavulans, Bolmsjö, Edberg, & Ojehagen, 2012).

In the third theme, "Social consequences/fear of guilt and shame from others mediating suicidality", working on societal norms might again increase the possibilities of one's next of kin being able to respond to the gambling addiction in a more understanding way. A worrying finding in this study was the experience of being in male-dominated group therapy sessions. Having reached out and realizing your gambling problem and then being treated as "the woman" in the group rather than a fellow individual with GD could be quite dangerous in terms of suicidality during a vulnerable time when an individual seeks help. This merits further investigation and should be considered when assisting women with GD.

Knowledge on women with GD and suicidality in general may reduce stigma. Although fear of stigma and self-stigmatization may be barriers to treatment seeking in general for people with GD (Hing & Russell, 2017), and perhaps even more so for women, it appears as if the knowledge gained in treatment reduces this stigma (Dąbrowska & Wieczorek, 2021). Involving close family members in treatment may also help to reduce such feelings. This study shows the importance of having a therapist who one trusts. The ability to provide such therapeutic contacts appears to be something that should be strengthened in health care and social services. Further, economic consequences appeared important in the development of as well shame as a sense of loss of control but also appeared for some to be a reason to why near ones had a hard time accepting and providing support for the

affected women. Regulations for gambling providers and loan givers might thus be important to address the issue of gambling-related suicidality.

Limitations: Results are to be interpreted cautiously and further studies are needed to assess external validity. All authors shared a common preunderstanding of the subject as can be seen in the methodology section which might impact interviews as well as interpretations of themes and categories. We further chose not to indicate which interview contributed with specific citations to diminish the risk of identifying the women due to the low sample size although this impacts internal validity (Korstjens & Moser, 2018). We chose to investigate suicidality in individuals with GD rather than the full spectrum of problem gambling which should be kept in mind when interpreting the results. This approach was chosen due to the authors' interest in clinical research potentially improving treatment and understanding of suicidality in women with GD as health care and social services only recently were made responsible for the treatment of GD in Sweden (Socialstyrelsen, 2017). However, further research focusing on the spectra of women with gambling-related problems would be very much of interest for primary prevention (Armstrong, Rockloff, Browne, & Blaszczynski, 2020). Finally, all interviews were held in Swedish possibly biasing the results as Malmö is a multi-ethnic town with high rates of immigration (Malmö Stad, 2021). This bias might already be at the treatment level, and it is our clinical impression that very few individuals not speaking fluent Swedish are diagnosed in health care nor receive treatment within the social services.

Strengths: This is, to the best of our knowledge, the only published study that describes suicidality in women with GD. As such it provides novel knowledge and ideas on the suicidal process in women with GD. We hope to shed light on a field that, in our opinion, is vastly understudied. The interviews were conducted by a licenced doctor with research experience on GD-related suicidality at the local treatment unit "Triangelmottagningen" in Malmö, Sweden, which provided a safe environment for the interviews. The material from the interviews, in our opinion, was rich in terms of women sharing traumatic, personal, and life-changing experiences as well as describing their past or sometimes present suicidality. Furthermore, a GD diagnosis could be precisely evaluated due to the scope of the interview providing information on which to base a diagnosis using DSM-V criteria with two different medical doctors reading the interview (American Psychiatric Association, 2013). The semi-structured interview format and discussion on the transcribed material throughout the process aided in increasing dependability (Graneheim & Lundman, 2004).

Conclusion: All women had experienced suicidality and six of them described suicidality due to their gambling. Three themes of suicidal mediators were created: "Guilt, shame, and self-stigmatization mediating suicidality", "Loss of control/chaotic life circumstances mediating suicidality" and "Social consequences/fear of guilt and shame from others mediating suicidality". More research on the experience of suicidality in women with gambling disorders is needed, but addressing self-stigmatization, guilt, and shame in women with gambling disorders as well as in society at large may be avenues to reduce suicidality while also assisting women to regain a sense of control over their economy and gambling. Finally, there is a clear need for suicide risk assessments in the care of individuals with gambling disorders.

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Authors' contributions: AK, AH and HH all participated in the study concept and design. AK and AH obtained funding. Interviews were held by, coded by, and transcribed by AK. AK, AH and HH built categories and themes. AK wrote the paper under the supervision of HH and AH.

Conflict of interest: AH is a professor at Lund University, a position funded by a collaboration between Lund University and the Swedish gambling monopoly, Svenska Spel AB, as part of the latter's responsibility for gambling and research policy. AK has received a grant from the same gambling operator monopoly, Svenska Spel AB as part of Svenska Spel AB's responsibility for gambling research. HH declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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APPENDIX

Intervjuguide version 2 (in Swedish with an English translation below)

1. Välkomnande och introduktion av studie och av mig själv (AK).
2. Information om kort journalföring.
3. Förklaring kring ljudinspelning och transkription sam möjlighet till avbrytande av studie eller om man senare önskar ångra sitt deltagande.
4. Göra en diagnostisk skattning av spelberoende innan intervjun om diagnos ej finns.
5. Diktafon sätts på.
6. Berätta varför du tackade ja till att delta i studien.
7. Berätta lite om dig själv, vem är du?
   a. Partner – sexuell orientering
   b. Barn
   c. Relationer och ensamhet
   d. Arbete
   e. Ekonomi
   f. Trosuppfattning
   g. Livshändelser
   h. Utsatthet för brott
   i. Psykisk ohälsa
   j. Alkohol och drogvanor.
8. Berätta om hur ditt spelande började.
9. Hur är ditt spelande idag / när det var som värst.
10. Berätta om hur spelandet fått dig att må.
11. Berätta om när du har mått som sämst.
    a. Hade du några suicidtankar då?
    b. Gjorde du något självmordsförsök?
    c. Vad ledde upp till dina suicidtankar/ditt suicidförsök?
    d. Varför tror du att du mådde så dåligt just då / riskfaktorer
       - spelandets betydelse
       - trauman
       - livshändelser
       - ekonomi
       - andra faktorer ?
    e. Berättade du för någon att du mådde så dåligt?
    f. Sökte du vård under den här tiden?
    g. Fick du någon hjälp som var bra eller dålig?
    h. Vad har fått dig att orka härefter/skyddsfaktorer?
12. BERÄTTA HUR DU SER PÅ SPELET /SUICIDTANKARNA
13. Vilka är de 2-3 största skillnaderna mellan spelet och suicidtankarna?
14. Berätta om senaste gången du spelat.
15. Vilka råd skulle du ge till någon som är i en liknande situation?
16. Hur tror du att en idealisk vårdkontakt ser ut?
    i. Använd en bild för att beskriva det.
17. Berätta hur din behandling ser ut en vanlig dag.

18. Kan vården bli bättre?
19. Spel suicid socialt nätverk vård och våld.
20. Berätta vad du tror hjälper dig i vården
    1. Tillgänglighet
    2. Personkemin
    3. Metod.
21. Berätta lite om dig själv idag och hur du ser på din framtid.
22. Stort tack!

English translation:

1. Welcoming and introduction to the study and of myself (AK).
2. Information on short medical journal entry.
3. Explaining audio recording, transcription, and possibility to withdraw study consent.
4. Making a diagnostic evaluation should the gambling disorder diagnosis not be present in the medical journal.
5. Dictaphone is switched on.
6. Tell me why you chose to accept the invitation to partake in the study.
7. Tell me a bit about yourself, who are you?
    a. Partner – sexual orientation
    b. Children
    c. Relations and loneliness
    d. Work
    e. Economy
    f. Belief system
    g. Life events
    h. Criminal victimization
    i. Mental unhealth
    j. Substance use
8. Tell me about how your gambling begun.
9. How is your gambling today / when it was at its worst.
10. Tell me how the gambling makes you feel.
11. Tell me about when you felt at your worst.
    a. Did you have any suicidal thoughts at that time?
    b. Did you do any suicide attempt?
    c. What led up to your suicide thought/ your suicide attempt.
    d. Why do you think you felt so unwell at that time /risk factors
        - the impact of gambling
        - trauma
        - life events
        - economy
        - other factors.
    e. Did you share that you were feeling so unwell with anyone?
    f. Did you seek professional help during this time?
    g. Did you receive any help that was good or bad?
    h. What has made you carry on after this time/ protective factors?
12. TELL ME HOW YOU VIEW THE GAMBLING/ THE SUICIDAL THOUGHTS
13. Which are the 2-3 biggest differences between the gambling and the suicidal thoughts?
14. Tell me about the last time you gambled.
15. Which advice would you give someone else in a similar situation?
16. How do you think an ideal treatment contact should be
    i. Use a picture to describe it.
17. Tell me about how your treatment looks on a regular day.
18. Can treatment improve?
19. Gambling, suicide, social network, and violence.
20. Tell me what you think helps you in your treatment:
    a) Availability
    b) Personal chemistry
    c) Methodology?
21. Tell me about yourself today and how you look at your future.
22. Thank you very much!