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From coming to terms with the gambling problems to post-traumatic growth: A novel nine-stage theoretical model of recovery from gambling disorder

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FULL-LENGTH REPORT

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ABSTRACT

Background and aims: The concept of recovery is gaining increasing relevance in gambling disorder (GD). Rooted in the users' movement, recovery is viewed as a process involving non-medical and subjective dimensions. However, qualitative research on this topic remains limited, and no consensus exists on its definition. This study aimed to develop a theoretical model of recovery, examining stages, dimensions, and conditions shaping recovery trajectories from a holistic, patient-centred perspective. *Methods:* Semi-structured interviews were conducted with 10 self-defined recovered gamblers and 10 self-defined currently recovering gamblers. Data were analysed using an inductive and comparative approach based on constructivist grounded theory (CGT). *Results:* A novel nine-stage theoretical model of recovery was developed: (1) Coming to terms with gambling problems; (2) Framing GD as a medical condition; (3) Acknowledging accountability; (4) Deciding to change and making an initial commitment to recovery; (5) Constructing one's recovery goal; (6) Maintaining long-term commitment; (7) Reclaiming autonomy and agency; (8) Rebuilding through recovery; and (9) Post-traumatic growth. The model identifies key dimensions that shape progression and conditions (facilitators and barriers) associated with each stage. Both groups mentioned all stages, though experiences differed depending on recovery status. Shared and group-specific facilitators and barriers were observed across stages. *Discussion:* Findings show that recovery is a multidimensional process, extending beyond behavioural change to include meaning-making processes and identity renegotiation. *Conclusions:* Results emphasise the need for a holistic, patient-centred approach. Qualitative research offers insights to inform tailored, recovery-oriented interventions and contribute to a unified, multi-stakeholder definition of recovery.

KEYWORDS

gambling disorder, problem gambling, recovery, qualitative study, semi-structured interviews, in-depth interviews

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INTRODUCTION

Behavioural addictions, also referred to as non-substance addictions, describe addictive disorders in which the object of addiction is not the use of a substance but the repetition of a

behaviour. The WHO defines "disorders due to addictive behaviours" as "clinically significant syndromes associated with distress or interference with personal functioning that develop as a result of repetitive rewarding behaviours other than the use of dependence-producing substances" (WHO, 2022). Within the ICD-11, gambling disorder (GD) and gaming disorder are the only recognised behavioural addictions. GD is also the only behavioural addiction currently recognised in the DSM-5, where it is defined as a "persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress" (APA, 2013).

Contemporary models conceptualise GD as a behavioural addiction sharing core psychological, neurobiological, and neurocognitive mechanisms with substance use disorders (SUDs), including altered reward processing, impaired inhibitory control, maladaptive learning processes, and common features such as craving, tolerance, and withdrawal (Brand et al., 2025; El-Guebaly, Mudry, Zohar, Tavares, & Potenza, 2012). In addition, the development and maintenance of GD are influenced by multiple risk factors, including psychosocial characteristics such as being male, young, single or recently married, living alone, having a low level of education, experiencing financial difficulties, encountering social and family problems, and presenting mental health comorbidities (Moreira, Azeredo, & Dias, 2023). Moreover, a reciprocal dynamic exists between these risk factors and the impacts of GD, as the disorder can affect multiple life domains (financial, cultural, emotional/psychological, legal, health, relationships, and work or education) (Fong, 2005; Langham et al., 2016). Finally, from a public health perspective, recent work also highlights major challenges associated with gambling-related harm, including inequalities in exposure and vulnerability, barriers to treatment access, and the need for comprehensive prevention and regulatory strategies (Bowden-Jones et al., 2022; Wardle et al., 2024).

Given the complexity and heterogeneity of GD, treatment requires an integrative approach that considers factors associated with treatment effectiveness, dropout and relapse, and the importance of tailoring to the diverse profiles and needs of individuals with gambling problems (Bowden-Jones et al., 2022; Czakó et al., 2025). From this perspective, the recovery approach appears particularly relevant. Stemming from the users'/consumers' movement in Western countries during the 1980s–1990s, this paradigm has reshaped services and policies to become more recovery-oriented (Anthony, 1993; Davidson & White, 2007; White, 2004, 2005). This shift responds to the limits of the medical model, which defines recovery through clinical remission (i.e., absence of symptoms) or functional remission (i.e., regaining a satisfactory level of functioning in daily life)—an endpoint inadequate for psychiatric and addictive disorders, given their chronic, relapse-prone course and wide-ranging biopsychosocial impacts (Bellack, 2006; Davidson & Roe, 2007; Laudet, 2011). These features underscore the need to conceptualise recovery as a broader, ongoing process encompassing subjective dimensions such as building a healthy, meaningful, productive, and satisfying life (ASAM, 2013; Ashford et al., 2019; Davidson et al., 2008; el-Guebaly, 2012; Jacob, 2015; SAMHSA, 2012; Witkiewitz, Montes, Schwebel, & Tucker, 2020). Research in behavioural addictions also supports a holistic understanding of recovery. For instance, a recent scoping review on gaming disorder indicates that recovery is typically conceptualised as a multidimensional process, encompassing psychological and social components beyond symptom reduction (Gavriel-Fried et al., 2023). Similarly, qualitative research on compulsive sexual behaviour illustrates how individuals initially pursue abstinence but progressively redefine recovery as involving personal growth, identity transformation, and broader improvements in quality of life (Fernandez, Kuss, & Griffiths, 2021).

A major challenge in this field is the absence of consensus regarding the definition of recovery, whether in mental health (Bonney & Stickley, 2008), or addiction, including GD (Nower & Blaszczynski, 2008; Walker et al., 2006). A systematic review conducted by Pickering, Keen, Entwistle, and Blaszczynski (2018) showed that the diffuse nature of the concept contributes to variability in reported outcomes in GD treatment studies. A more recent scoping review confirmed this, highlighting substantial discrepancies in how recovery is defined—ranging from abstinence and controlled gambling to no longer meeting diagnostic criteria, reduced severity, or functional remission. Outcome measures also varied widely, from gambling-specific to broader well-being indicators. This scoping review also offered a meta-synthesis of qualitative studies, highlighting significant limitations in quantitative and instrument validation studies in capturing recovery from GD in a holistic and patient-centred perspective (Mansueto, Challet-Bouju, Hardouin, & Grall-Bronnec, 2024).

However, qualitative research on recovery from GD remains limited (Mansueto et al., 2024; Pickering, Spoelma, Dawczyk, Gainsbury, & Blaszczynski, 2020) and, to our knowledge, no such study has yet been conducted in France. Given the lack of definitional clarity and the gap between medical and biopsychosocial perspectives, further qualitative studies are needed to explore gamblers' subjective experiences, including factors that facilitate or hinder recovery. Examining these facilitators and barriers is essential for fully understanding the complexities of the recovery process. By doing so, such research can contribute to a more holistic, patient-centred conceptualisation of recovery, with implications for researchers, clinicians, and policymakers involved in public health and recovery-oriented services. We therefore decided to conduct a qualitative study based on in-depth interviews with gamblers who self-identified as either recovered or currently recovering. The objectives were to: (1) develop a theoretical model of the recovery process grounded in participants' experiences; (2) examine how different dimensions interact to shape recovery trajectories; (3) identify conditions enabling progression through recovery stages; and (4) explore how self-defined recovery status (recovered vs. in recovery) intersects with the different components of the recovery process (stages, dimensions, and conditions).

METHODS

This study adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury, & Craig, 2007), as well as to the Journal Article Reporting Standards for Qualitative Research (JARS–Qual) of the American Psychological Association (Levitt et al., 2018), ensuring rigorous and transparent reporting.

Theoretical framework

This qualitative study is grounded in a constructivist paradigm, which posits that reality is socially constructed through human interaction and shared meanings (Charmaz, 2006/2014; Guba & Lincoln, 1994). It adopts a relativist ontology, recognising multiple subjective realities shaped by individuals' contexts and experiences, and a subjectivist epistemology, in which researchers and participants co-create knowledge through their interactions, meaning that findings emerge from the research process rather being discovered as pre-existing truths (Guba & Lincoln, 1994; Urcia, 2021).

Methodology

Aligned with this framework, we employed a constructivist grounded theory (CGT) approach (Charmaz, 2006/2014). Grounded theory uses a systematic and comparative method to understand patterns of social processes and the conditions that shape them, generating theoretical knowledge grounded in data (Urcia, 2021). CGT, as proposed by Charmaz (2006/2014), recognises the researcher's active role in the analytical process, with theories emerging through interaction with data. This approach is particularly suited to studying recovery, enabling the development of process-oriented models that capture both commonalities and variations in how individuals experience and navigate change over time.

Participants

The study employed purposive sampling, specifically criterion sampling, to recruit individuals who self-identified as recovered or currently recovering from GD. Potential participants were informed about the study by their former or current treating clinician or support group therapist, who provided their perspective on the participant's recovery status without determining eligibility. This approach ensured that inclusion was based on participants' subjective experience while allowing recruitment to be informed by clinical insight. Including participants from both recovery statuses constituted our maximum variation sampling, capturing diversity in recovery trajectories and experiences. This distinction between recovered and currently recovering participants reflects a dual conceptualisation of recovery as both a process and a sustained status (White, 2007), serving as an analytical lens to examine variations in recovery experiences.

Forty-one individuals were approached. Thirty-nine were identified through the addiction service at Nantes University Hospital, via one study author (MGB, psychiatrist at the service) who presented the study during individual or group treatment sessions, then emailed interested patients. She also invited former patients—no longer in follow-up due to recovery—by email. Two additional individuals were identified through a mutual support group, via the group's therapist. The interviewer (AM), who had no prior relationship with participants, recontacted those who expressed interest. She introduced herself, explained the study's objectives, and provided information about the interview (duration, anonymity). Of the 39 individuals from the addiction service, 19 were recruited, and one of the two from the support group was included. A flow diagram of participant recruitment is provided in Fig. 1.

The final sample included 20 participants, evenly split between recovered (n = 10) and currently recovering (n = 10), facilitating comparative analysis of how individuals at different points in their recovery journey experience and navigate change. This sample size aligns with CGT, which emphasises rich, detailed data over statistical representativeness. Charmaz (2006/2014) notes that grounded theory studies typically rely on small to medium-sized samples, with data collection continuing until theoretical saturation is reached. In our study, theoretical saturation was achieved when no new dimensions or conditions emerged, and additional data contributed only idiosyncratic variations.

Most participants were men (n = 14), aged 27–72 (M = 46, SD = 13). Two were under legal protection, 13 lived with a partner, and 14 were professionally active. Educational backgrounds were distributed as follows: 3 had no qualification, 5 had vocational certificates, 3 had completed high school (baccalaureate), 4 held a Bachelor's degree, and 5 held a Master's degree. Regarding gambling, 12 participants engaged exclusively in one form: table games and slot machines (n = 3), lottery (draw-based and scratchcard games; n = 3), horse race betting (n = 1), and sports betting (n = 5). Eleven participants were still gambling at the time of study, with two considering themselves recovered. Among these active gamblers, nine had significantly modified their gambling practices, over 1 month to 10 years. Among the nine who had stopped gambling, one still identified as currently recovering, with abstinence ranged from 3 weeks to 11 years. Detailed sociodemographic and gambling-related characteristics of participants are presented in Table 1.

In the currently recovering group (n = 10), nine participants were still gambling with significant modifications (<3–12 months), and one had achieved abstinence for under 3 months. In the recovered group (n = 10), eight maintained complete abstinence (ranging from under 3 months to over 3 years), while two continued controlled, non-problematic gambling for over 3 years. Group self-assignment reflected a multidimensional conception of recovery encompassing psychosocial functioning, quality of life, and well-being, rather than gambling status alone. For example, one participant abstinent for less than 3 months was classified as recovered based on broader life reconstruction, while another with similar abstinence duration remained in the

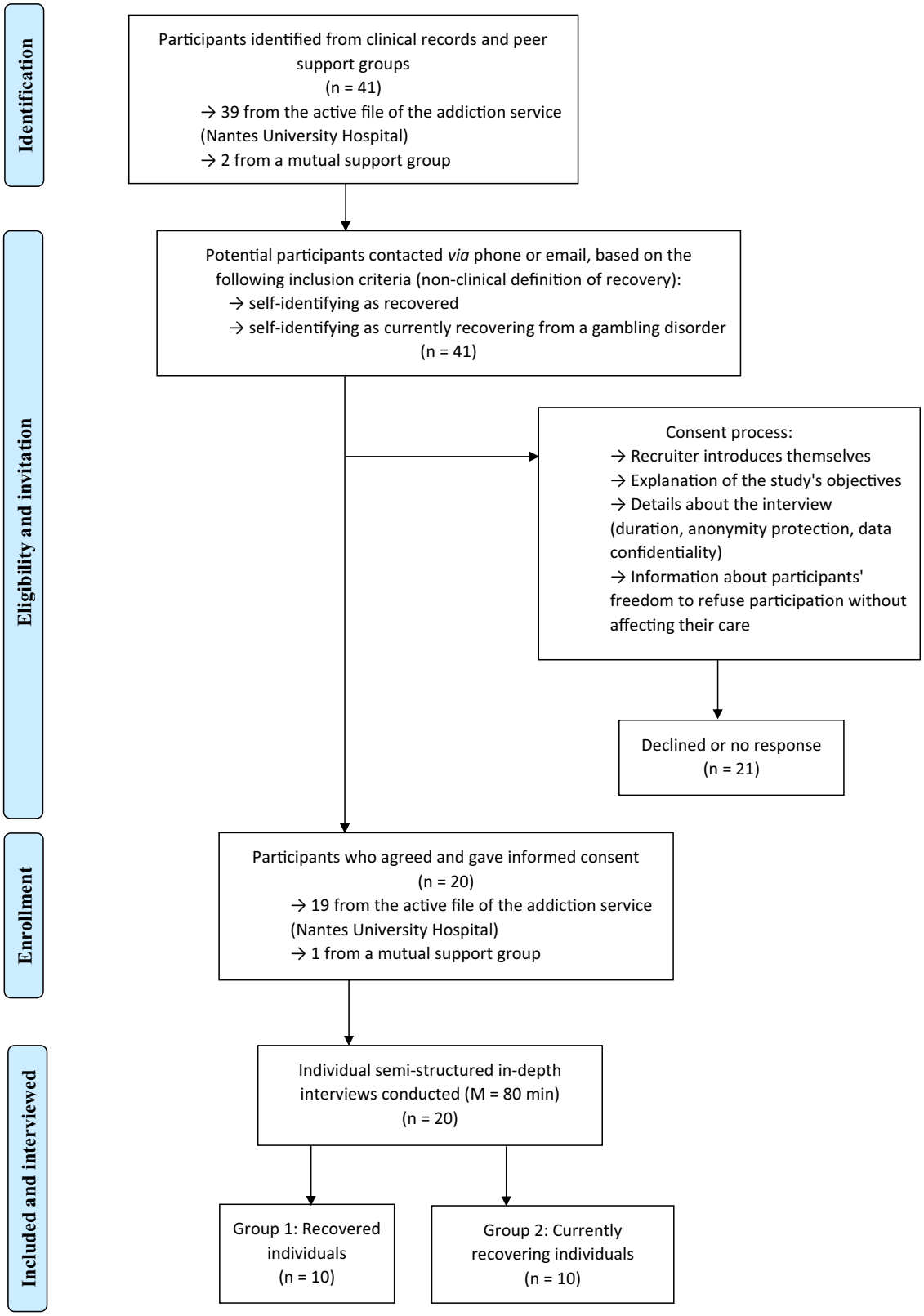

Fig. 1. Flow diagram of the participants' recruitment process

Table 1. Participants' sociodemographic and gambling-related characteristics

Sociodemographic characteristics			
Variable	Total (N = 20)	Recovered gamblers (n = 10)	Currently recovering gamblers (n = 10)
Gender			
Male	14 (70%)	7 (70%)	7 (70%)
Female	6 (30%)	3 (30%)	3 (30%)
Age			
18–34	6 (30%)	1 (10%)	5 (50%)
35–54	7 (35%)	5 (50%)	2 (20%)
55+	7 (35%)	4 (40%)	3 (30%)
Legal protection	2 (20%)	2 (20%)	0 (0%)
Marital status			
In a relationship (married, civil partnership, or cohabiting)	13 (65%)	7 (70%)	6 (60%)
Single (unmarried, divorced, separated, or widowed and not entered into a new partnership)	7 (35%)	3 (30%)	4 (40%)
Employment status			
Employed	14 (70%)	6 (60%)	8 (80%)
Not employed (retired or on disability benefits)	6 (30%)	4 (40%)	2 (20%)
Education			
No professional qualification (no diploma or middle school only)	3 (15%)	1 (10%)	2 (20%)
Vocational certificates	5 (25%)	3 (30%)	2 (20%)
High school completed (baccalaureate)	3 (15%)	3 (30%)	0 (0%)
Bachelor's degree	4 (20%)	1 (10%)	3 (30%)
Master's degree	5 (25%)	2 (20%)	3 (30%)
Types of gambling			
Variable	Total (N = 20)	Recovered gamblers (n = 10)	Currently recovering gamblers (n = 10)
Poker only	0 (0%)	0 (0%)	0 (0%)
Tables games and slot machines (casino establishments and gambling clubs) only	3 (15%)	1 (10%)	2 (20%)
Lottery (draw-based and scratchcard games) only	3 (15%)	1 (10%)	2 (20%)
Horse race betting only	1 (5%)	1 (10%)	0 (0%)
Sports betting only	5 (25%)	3 (30%)	2 (20%)
At least two types of gambling	8 (40%)	4 (40%)	4 (40%)
Abstinence			
Variable	Total (N = 20)	Gamblers recovered (n = 10)	Currently recovering gamblers (n = 10)
Abstinent	9 (45%)	8 (80%)	1 (10%)
Still gambling	11 (55%)	2 (20%)	9 (90%)
Length of abstinence			
Variable	Total (N = 9)	Gamblers recovered (n = 8)	Currently recovering gamblers (n = 1)
<3 months	2 (22%)	1 (13%)	1 (100%)
3–12 months	2 (22%)	2 (25%)	0 (0%)
1–3 years	2 (22%)	2 (25%)	0 (0%)
>3 years	3 (33%)	3 (38%)	0 (0%)
Modified gambling practices			
Variable	Total (N = 11)	Gamblers recovered (n = 2)	Currently recovering gamblers (N = 9)
Modified gambling practices	9 (82%)	2 (100%)	7 (78%)
No modification	2 (18%)	0 (0%)	2 (22%)
Length of modified gambling practices			
Variable	Total (N = 9)	Gamblers recovered (n = 2)	Currently recovering gamblers (N = 7)
<3 months	1 (11%)	0 (0%)	1 (14%)
3–12 months	6 (68%)	0 (0%)	6 (86%)
1–3 years	0 (0%)	0 (0%)	0 (0%)
>3 years	2 (22%)	2 (100%)	0 (0%)

currently recovering group, still engaged in therapeutic work toward holistic recovery.

Procedure

Following consent, participants completed an online self-reported questionnaire. The interviewer then scheduled a single interview with each participant, either in person (at the addiction service of Nantes University Hospital) or via video conference, resulting in 20 interviews. All interviews were conducted by AM between May 2023 and August 2024, with no one else present. Semi-structured, in-depth interviews were used for data collection (Louise Barriball & While, 1994), lasting an average of 80 min (SD = 13). Interviews were audio-recorded and fully transcribed by AM, with most non-verbal elements (e.g., laughter, discomfort, silence) noted in the transcripts. Transcripts were not returned to participants to maintain the integrity of the research process and ensure responses remained authentic and uninfluenced, in line with standard qualitative research protocols. This approach also considered ethical concerns, as reviewing the transcripts could have been distressing for participants, who often discussed painful periods and events of their lives, and sometimes expressed strong emotions during the interviews.

Measures

Before the interview, participants completed a self-reported questionnaire covering (1) sociodemographic characteristics and (2) gambling behaviours (types of gambling activities, abstinence status and duration, and changes in gambling practices over time). The semi-structured interview comprised two chronological sections to facilitate recall and ensure logical progression: first, awareness of GD and subsequent health-related interventions (treatment-seeking, public health policies); then, the impact of GD on various life domains and improvements since engaging in recovery (activities, work, physical and mental health, relationships, finances). The interview guide was not pilot-tested due to recruitment challenges but was iteratively adapted throughout data collection—questions were reformulated or added as the study progressed—to explore emerging categories, their dimensions, and conditions, consistent with CGT's iterative analytical approach (Charmaz, 2006/2014). An English translation of the final version of interview guide, revised with AI assistance, is presented in Table 2.

Data analysis

We followed the principles of CGT (Charmaz, 2006/2014). Interviews were transcribed and initial coding began before data collection was complete, allowing emerging insights to inform the interview guide in line with CGT's iterative approach. Transcripts were analysed in NVivo 14, using an inductive approach, with categories, dimensions, and conditions constructed directly from the data rather than predetermined.

Initial coding was conducted line-by-line by the first author (AM) on a case-by-case basis to remain close to participants' language and attend to the specificity of each account before moving to cross-case analysis. Through constant comparison, related codes were progressively grouped into increasingly abstract analytical constructs during focused coding—from specific codes to dimensions representing different aspects of recovery phenomena, and finally to overarching categories. This process was iterative rather than linear: preliminary constructs at various levels of abstraction were regularly discussed with the research team (GCB, JBH, MGB), leading to their refinement, reclassification, and reorganisation as understanding deepened. Following Charmaz's (2006/2014) recommendation, axial coding strategies were integrated throughout to systematically explore relationships between constructs and identify conditions (facilitators and barriers) influencing recovery progression. The analytic progression from in vivo codes to conceptual categories is consistent with CGT's aim to generate theoretical understanding grounded in, but not limited to, participants' own framings. Psychological terminology was used where it accurately reflected shared patterns across accounts, while remaining anchored in participants' experiences. Regular team discussions ensured that abstract categories faithfully represented participants' meanings while supporting theoretical generalisation.

Elements were retained based on their (1) relevance for understanding recovery as a progressive process and characterising each stage; (2) potential to distinguish between "recovered" and "currently recovering" groups; and (3) significance in illustrating factors that facilitate or hinder progression. Through iterative refinement and constant comparison, we developed a processual model of recovery comprising sequential stages, each with its dimensions, facilitators, and barriers. The final analytical framework represents a consensus among all authors.

Research team and reflexivity

Researchers' backgrounds and prior understandings are detailed in Supplementary Material S1. These pre-understandings, shaped by prior research on gambling recovery and MGB's clinical experience, influenced several stages of the study.

First, MGB facilitated participant recruitment, which may have affected who chose to participate and how they framed their narratives.

Second, researchers' perspectives informed data collection. AM's philosophical background and focus on subjective experience shaped her interviewing style, encouraging open exploration of participants' meanings and interpretations. The scoping review she conducted before the study led her to probe aspects identified in prior work, without imposing predetermined definitions of recovery.

Third, familiarity with recovery frameworks provided sensitising concepts that guided early coding and the development of categories, dimensions, facilitators, and barriers. This may have oriented interpretation towards established vocabularies and explanatory schemes, but regular team discussions ensured that initial frameworks were

Table 2. Interview schedule

Themes	Main questions	Clarification questions	Key points to address during the interviews
Awareness of the gambling problem	How have you come to realise your gambling problem? Had you ever reflected on your gambling behaviour before recognising the problem?	Was there a particular event that triggered this realisation? To what extent have the negative consequences of gambling contributed to this realisation? Had you been questioning your gambling behaviour for a long time before recognising the problem?	• Awareness of having a gambling problem • Gradual vs. sudden realisation • Prior reflections on gambling behaviour before awareness • Recognition of the impact of gambling behaviour on one's life • Role of external factors (e.g., family, financial issues) in awareness
Motivation	Once you realised that your gambling had become a problem, how long did it take you to start taking steps to deal with it? What has led you to want to address your gambling problem? Despite your motivation to resolve your problem, have you encountered any difficulties that have hindered your motivation? If so, could you describe them?	Could you explain why there was a delay in your motivation to start taking action towards resolving the issue, even though you were aware of your gambling problem? Were there specific turning points that finally pushed you to take action? What aspects have made it difficult for you to maintain motivation during the recovery process?	• Internal motivating factors (e.g., personal health, financial situation, etc.) • External motivating factors (e.g., concerned significant others) • Barriers to motivation (e.g., withdrawal symptoms) • Sustained vs. fluctuating motivation patterns
Therapeutic support and treatment objective	Are you currently receiving therapeutic support for your gambling problem? If not, did you before? Can you explain the type of therapeutic support you are currently receiving or have received for your gambling problem? What has motivated you to seek therapeutic support? What has this therapeutic support brought to you? What goals have you set for yourself concerning your gambling problem?	How has the therapeutic support you've received helped you in achieving your goals? How have these objectives changed over time?	• Therapeutic support and its type • Recovery objectives and their evolution • Expectations of therapeutic support • Effectiveness (or lack thereof) of therapeutic support
Public health measures and personal prevention strategies	Are you currently using any public health measures (e.g., guardianship, voluntary self-exclusion, etc.)? If not, did you before? Which ones? Can you describe how effective you feel these measures have been in helping you address your gambling problem? Have you set financial limitations for yourself to avoid relapse, such as limiting payment methods or asking someone close to you to keep your bank card or monitor your account? How effective have your self-imposed financial limitations been in helping you resolve your gambling problem?	Could you explain why you haven't wanted to use these measures or set financial limitations for yourself?	• Expectations of public health measures • Expectations of financial self-limitations • Prejudices about public health measures • Reasons for not imposing financial limits on oneself (e.g., trust in one's own ability to self-limit; feelings of infantilisation; lack of sufficient relationships with close ones) • Lack of awareness of public health measures • Effectiveness (or lack thereof) of public health measures • Effectiveness (or lack of) of financial self-limitations

(continued)

Table 2. Continued

Themes	Main questions	Clarification questions	Key points to address during the interviews
Activities and employment	To what extent has gambling impacted your activities (e.g., sports or other leisure activities)? Since you have started working on resolving your gambling problem, have you resumed any of these activities? If so, which ones? Have you also engaged in any new activities? If so, which ones? Could you explain the importance of these activities in the resolution of your problem? Has gambling also impacted your employment? If so, in what way? Has this situation improved since you have begun working on resolving your problem? If yes, how?	Could you explain what has prevented you from resuming these previous activities or engaging in new ones? Could you elaborate on why there hasn't been improvement in your employment situation thus far?	• Impact of the gambling problem on activities • Resuming abandoned activities • Engagement in new activities • Importance of activities in recovery (substitution function: occupying free time to avoid thinking about gambling and not having time to gamble; or genuine importance for self-reconstruction and well-being) • Impact of the gambling problem on employment • Resolution (at least partial) of employment-related issues caused by the gambling problem
Financial situation	What financial issues have you encountered because of your gambling behaviour (e.g., debts)? How has your financial situation improved since you started addressing your gambling problem? To what extent have these financial issues affected other areas of your life? Have you been able to resolve, at least partially, the problems stemming from these financial issues?	What strategies have you used to address the problems caused by your financial difficulties? What factors have prevented your financial situation from improving? If you haven't resolved these issues, what obstacles have you encountered?	• Financial issues directly caused by gambling (e.g., debts, financial imbalance) • Improvement or resolution of financial problems and methods employed • Impact of financial problems on other life domains (e.g., social activities, relationships, trust issues with concerned significant others) • Any gambling-related illicit activities and their legal consequences • Steps taken to resolve secondary problems caused by financial issues
Mental health	To what extent has your gambling problem impacted your mental health? Have you noticed improvements in how you feel since you began addressing your gambling problem? Has working on your gambling problem ever made certain negative emotions worse or created new ones? If so, which ones?	Could you describe the specific areas where you have noticed improvements in your mental wellbeing (e.g., less stress, better sleep)? In your opinion, what factors have prevented you from experiencing better mental health during your recovery? Could you explain why addressing your gambling problem has sometimes intensified certain negative emotions or created new ones?	• Impact of the gambling problem on mental health • Mental health improvements (e.g., reduction of negative emotions such as stress, guilt, shame) • Psychological difficulties triggered by the cessation or reduction of gambling (e.g., when gambling was used as a coping strategy) • Progress regarding comorbid disorders (e.g., anxiety, depression) • Recovery status regarding co-addictions (e.g., alcohol, tobacco) • Potential switching addictions (e.g., replacing gambling with another potentially addictive behaviour)

(continued)

Table 2. Continued

Themes	Main questions	Clarification questions	Key points to address during the interviews
Social relationships	To what extent has your gambling problem impacted your social relationships (e.g., conflicts, breakups)? Since you began addressing your gambling problem, have you resolved (at least in part) any of your relational difficulties? Could you describe how important support from your loved ones is/was in helping you overcome your gambling problem? Have you formed any new relationships since you began working on your gambling problem? Have you identified any relationships that you consider harmful to overcome your gambling problem?	Could you explain specifically how gambling has affected your social relationships? What obstacles have prevented you from resolving these relational problems? What factors have made it difficult for you to form new relationships? What specific forms of support have you received from your loved ones (e.g., listening, emotional support, practical help)? Have you considered distancing yourself from relationships that might hinder the resolution of your gambling problem? If not, what has held you back?	• Impact of the gambling problem on social relationships (e.g., deterioration of relationships and isolation) • Effects of gambling behaviour on concerned significant others (e.g., emotional distress, trust issues) • Process of (re)building social relationships and overcoming isolation • Strategies for rebuilding trust and establishing honesty in relationships • Nature and importance of support from concerned significant others • Identification and management of potentially negative social influences on recovery
Quality of life and life satisfaction	Has your overall quality of life improved since you began resolving your gambling problem? Could you explain the specific ways in which your overall quality of life has improved? Looking back, do you feel more satisfied with your life now than before you started your recovery journey? What role, if any, does gambling play in your life today?	What factors have prevented your overall quality of life from improving? What specific changes have led to an improvement in your life satisfaction since you began addressing your gambling problem? Why do you think your life satisfaction has decreased despite your efforts to address your gambling problem? What do you think could help improve your life satisfaction?	• Improvements in overall quality of life • Comparison of life satisfaction before and after the beginning of the recovery process • Factors contributing to a greater sense of fulfilment and well-being • Factors hindering overall well-being • The place gambling currently holds in the participant's life

questioned and adjusted in light of the data. MGB's clinical experience and longstanding reflection on how to conceptualise recovery in addiction contributed to maintaining a broad, exploratory perspective during analysis and to attending to dimensions of change that extend beyond symptom reduction and behavioural or cognitive change. JBH's more quantitative background and initial lack of strong preconceptions fostered conceptual clarity and openness, while GCB's view of recovery as a continuum and a plural process encouraged attention to diversity in participants' accounts and representation of recovery as situated and multidimensional rather than uniform.

In addition, conducting a qualitative study on recovery without prior knowledge of the field appeared problematic, as we would likely have overlooked essential dimensions highlighted by previous research and clinical experience. Rather than treating prior knowledge as bias to be eliminated, the team approached it as a heuristic resource, enabling dialogue with the phenomenon under study without preventing us from remaining open to what emerged from participants' accounts and to the questioning of our initial preconceptions. Pre-understandings were continuously confronted and enriched by empirical findings, consistent with Charmaz's CGT (2006/2014), which views reality as co-constructed through interaction rather than an objective datum to be discovered. Interpretations were evaluated for coherence, grounding in data, and resonance with participants' lived experiences.

Trustworthiness

To ensure the trustworthiness of our findings, we followed established qualitative criteria as proposed by Lincoln and

Guba (1985) and cross-checked our approach against Ahmed (2024) contemporary synthesis.

Credibility was supported through prolonged, in-depth interviews, ensuring the plausibility of our interpretations. Although persistent observation is often recommended, it was not feasible due to practical constraints. Reflexivity was maintained via a preliminary reflective exercise by each researcher documenting prior knowledge, professional experience, and potential preconceptions (see Supplementary Material S1). Triangulation was ensured through multiple data sources, including interviews, a prior scoping review, and comparison with existing literature on gambling recovery. Transferability was enhanced through detailed reporting of participants' sociodemographic characteristics, recruitment context, and purposive sampling rationale, enabling readers to assess applicability to other contexts. Dependability was supported by transparent description of the analytic process, including coding and categorisation steps. Confirmability was maintained via consensus discussions among all authors during construction of the theoretical model, its categories, dimensions, and conditions, ensuring findings reflect participants' perspectives rather than researchers' biases. Limitations related to the absence of member checking and formal reflexive journaling are discussed in the Limitations section.

Ethics

The research protocol was approved by the CEDIS (Ethics, Deontology and Scientific Integrity Committee of Nantes University) on February 21, 2024 (reference *n*°21022024-1).

After initial contact, participants were sent a secured online link to confirm their willingness to participate before any data collection began. During the recruitment process, potential participants were clearly informed that participation was entirely voluntary and that refusal to participate would not affect their care or treatment in any way.

The study was conducted in accordance with Good Clinical Practice Guidelines and the Declaration of Helsinki. No compensation was given for participation.

RESULTS

The process of recovery

Results emphasise that recovery is a non-linear and dynamic process. Nine stages were identified: (1) Coming to terms with the gambling problems; (2) Framing GD as a medical condition; (3) Acknowledging accountability; (4) Deciding to change; (5) Constructing one's recovery goal; (6) Maintaining long-term commitment; (7) Reclaiming autonomy and agency; (8) Rebuilding through recovery; and (9) Post-traumatic growth. For each stage, the analysis identified its constitutive dimensions (key elements characterising that stage) and conditions—facilitators and barriers—that influence progression. Some conditions were stage-specific, while others operated transversally across multiple stages.

Results are presented chronologically. This order does not reflect individuals' actual, lived experience—individuals may move between stages, regress, or skip stages—but serves to conceptualise recovery as an ideal-type (Weber, 2011), illustrating a typical path that may be followed during the *recovery journey* (Nixon & Solowoniuk, 2006; Nuske & Hing, 2013). This aligns with CGT's aim of developing theoretical models that abstract patterns across cases while remaining grounded in participants' accounts (Charmaz, 2006/2014). Figure 2 provides an overview of the nine-stage recovery process, with key facilitators and barriers.

For all quotations, "RG" refers to recovered gamblers and "CRG" to currently recovering gamblers, followed by a number. This pseudonymisation preserves participants' confidentiality. As interviews were conducted in French, quotations were translated into English using AI to preserve participants' tone, as the authors, non-native English speakers, could not fully capture their spontaneous and natural language.

Stage 1: coming to terms with the gambling problems

The first stage involves coming to terms with one's condition —progressively constructing meaning around its implications and the need for change. While no specific dimensions are identified at this point, participants in both groups described shared barriers and facilitators shaping their path to awareness.

In both groups, awareness is often delayed by the intensity of emotional responses confronting a difficult reality, described as "*vertiginous*" (CRG08) or "*unbearable*" (CRG05). Consequently, participants avoid engaging with this reality, either by "*putting on blinders*" (CRG05), or by "*just putting it aside*" (CRG07). Some refuse to accept it:

> I think I always knew it would end like this…. But I didn't want to accept it. I think there was a part of me saying, "no, it's not possible." (CRG06)

Two forms of distancing emerge in both groups. First, denial, where participants fail or refuse to construe their behaviour as problematic: "*I hadn't realised it. Well, I probably did, but I denied it—I was in denial*" (CRG09). Second, active minimisation, downplaying the seriousness of their actions: "*because for a long time, you convince yourself… that it's not pathological, that it's just a hobby, and that you have it under control*" (CRG08).

As a result of these combined barriers, the emergence of problem awareness can take, in both groups, "*a little time*" (RG16), "*a long while*" (CRG08), or even "*ages*" (CRG01).

In both groups, awareness typically unfolds gradually as negative consequences accumulate. Financial losses often act as a catalyst: "*it's the big financial losses that leave you no choice but to face the truth*" (CRG09). Personal repercussions also challenge denial:

> Actually, the fact that it touched my professional life and that it was starting to show, everywhere, well then it just wasn't possible anymore. And I think without that I would have kept sinking, well, staying in denial, let's say. (CRG06)

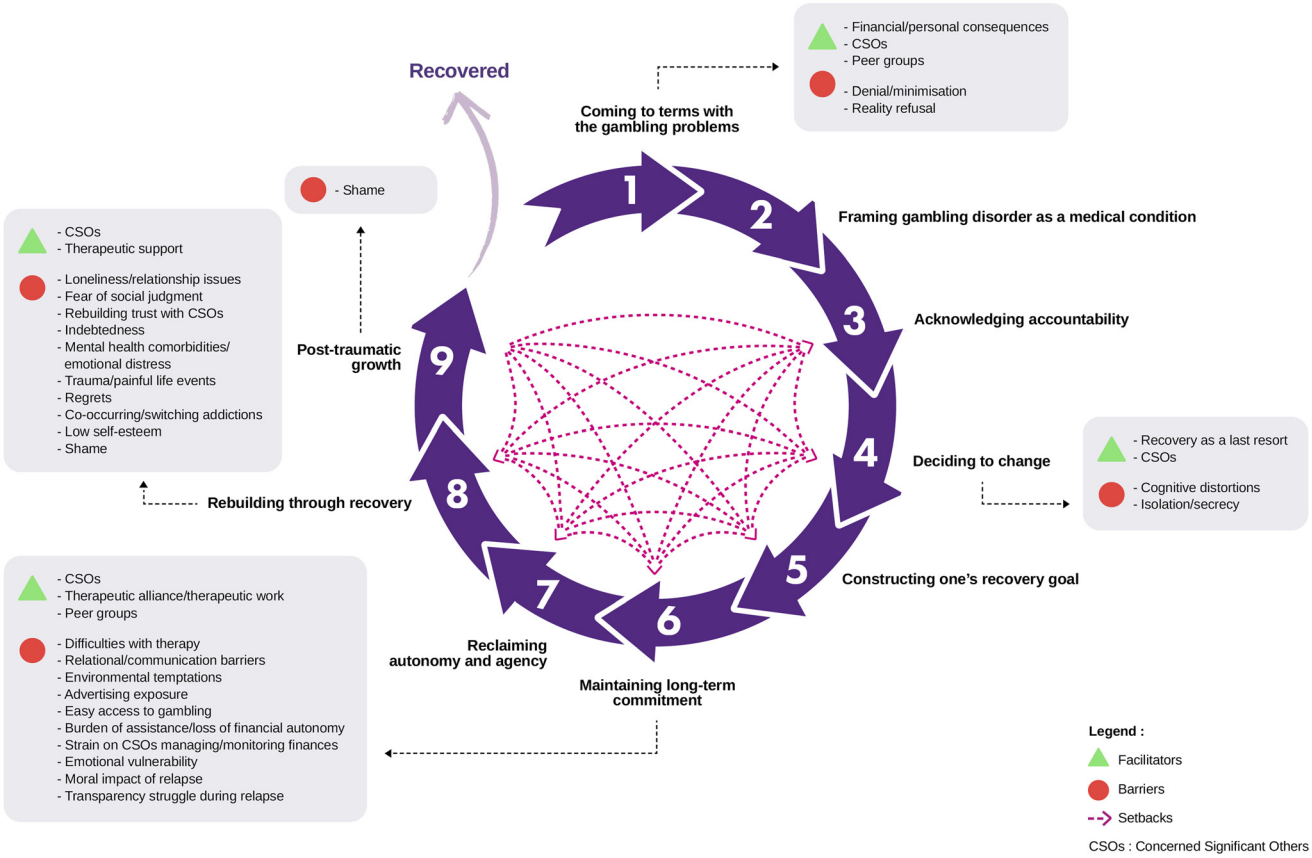

Fig. 2. Nine-stage theoretical model of the recovery process from gambling disorder

In both groups, concerned significant others (CSOs) facilitated awareness by prompting participants to recognise their gambling behaviour as problematic: "*if I had to point to a specific moment, it's when my wife realised the extent of the damage and kind of put me in front of it. Maybe having someone so close make me open my eyes*" (CRG05).

In both groups, peer support groups contributed to participants' understanding of their gambling problems through shared experiences and collective reflection: "*just talking about the addiction I had, I think that, little by little… it made me truly realise the situation I was in*" (CRG01).

Stage 2: framing GD as a medical condition

At this stage, three main dimensions emerge; no specific barriers or facilitators are identified.

Internal and external stigma reduction. In both groups, framing GD as a medical condition contributes to reducing both self- and external stigma. Internally, it helps release personal guilt:

> I don't consider it my fault that I'm in this situation *(sighs)*… I see it as an illness, and it can happen to anyone… I think it would be a mistake, actually, to tell yourself you're responsible, because the psychological impact of this addiction on us is already heavy enough. (CRG08)

Externally, it provides a framework to mitigate fear of social judgment:

> Today, I wouldn't be afraid of being judged, because I'd have the answer. I've accepted that it's an illness… and now I could say "first, who are you to judge me? Who are you? And it happens to everyone to be sick with something." (RG13)

A catalyst for understanding and tolerance from CSOs. Presenting GD in medical terms fosters understanding and tolerance among CSOs, ultimately leading to support: "*but in the end, they understood why, and that I wasn't doing it out of spite that, well, it's a real illness, that's all, it's just like that. So they didn't hold it against me, no, no, it turned out to be quite a quick support*" (RG11).

Negotiating the "addiction" label. However, in both groups, adopting this medical framework is not straightforward. The label "addiction" and the negative connotations associated with the word "addict" can feel stigmatising. This can lead participants to resist fully claiming the diagnosis:

> It's good to know that… we have a problem. That has to be admitted. If we don't admit it, we can never recover. And I recommend to anyone who has an addiction to go see someone, it really helps, to talk about it. But you have to use that word, addiction. It's really hard—addiction. Addiction means addict, and the word addict means that we're hooked, you know, and that's the word I don't like—addiction. (CRG04)

Stage 3: acknowledging accountability

This third stage encompasses four dimensions, all addressed by participants in both groups, with some nuances between them.

A starting point of recovery. Acknowledging responsibility for GD and its consequences represents, for both groups, a crucial step toward recovery, marking "*the very start of the process*" (CRG07). Yet, this can be difficult and painful: *"it's not easy to face that either, but at some point, well, that's it, I messed up, and I have to own it because otherwise, I could stay like this for five, ten, fifteen years"* (CRG05).

Positioning oneself as solely responsible. Participants in both groups emphasise exclusive personal responsibility, rejecting external factors as primary explanations. They dismiss institutional actors—such as gambling operators: "*I know I'm 100% responsible. I wouldn't say it's the lottery operator that got me into this, it's me who went there every time*" (CRG01). They also reject advertising: "*the ads are attractive, but not enough to trigger anything… It really comes down to the person themselves*" (RG20). Both groups also exclude social and relational factors: "*I think the initial question was whether I would have gone back to see people? No. Because the problem comes from me, it doesn't come from others*" (CRG06).

Recovered gamblers extend this principle further, minimising the role of personal and familial circumstances: "*but I never blamed anyone, my employer or my parents… it's me who put myself in this situation*" (RG15). Among them, responsibility is emphasised as a moral principle: "*well, if we're not responsible, then it's someone else's fault, or something else… No, no, that's too easy. It's easy. I knew where I was going, how it would end*" (RG17).

"Responsible but not guilty". For recovered gamblers specifically, rejecting such factors as excuses does not mean denying the influence they may have had on their behaviour: "*responsibility is still there, no one forced me to gamble… I actually chose it without really choosing. The gambling came to me, maybe during a period when things weren't going so well, when I was bored*" (RG19). They distinguish responsibility from guilt, allowing participants to acknowledge their role without excessive self-blame:

> Responsible, like you said, not guilty, that's the whole difference, you know. But when you gamble, a lot of people make you feel guilty, you know. Me, I was okay with being responsible, but not guilty. (RG16)

Transparency and accountability. Enacting responsibility also involves transparency with others, providing relief for both groups, who previously lived in secrecy and fear of discovery: "*now everything is smooth, you know, I don't need to hide things anymore*" (RG12); "*not living in that lie anymore, it's just* (takes a deep breath)*, it's liberating, clearly*" (CRG05).

Stage 4: deciding to change

This stage involves three dimensions, all mentioned by participants in both groups, with few differences between the groups.

Navigating ambivalence. At this stage, participants in both groups engage in a process of deciding whether to change, often delayed by ongoing tension between the desire to recover and the continued pull of gambling: "*I admitted that I was addicted to gambling, but I still wasn't mentally ready yet to stop it, absolutely*" (CRG01). In both groups, this hesitation is fuelled by cognitive distortions, particularly chasing: "*getting back what I've lost*" (CRG09, RG20). Consequently, several participants describe a state of learned helplessness, where the intention to stop is repeatedly postponed despite recognising the harm:

> You get into the system, and then you don't even realise, you know. You keep going, you keep going, you try to say "I'm gonna stop," the next day you say "I'm gonna stop," but then it's stronger than you, and you start again, you start again, you know, and you keep going. (RG15)

Committing to change and breaking free. When ambivalence is resolved, individuals commit decisively to a gambling-free life, as many participants in both groups emphasise: "*it's really decisive—I'm stopping gambling, it's over*" (RG16). In both groups, such a decision is often prompted by the accumulation of negative experiences culminating in a personal crisis, which acts as a "*turning point, the most decisive one*" (CRG02). This serves as a necessary catalyst for change:

> But in the end, luckily that happened. I mean, I probably couldn't have gone much further anyway, because my financial situation was a disaster, but at least that's what pushed me to go to the emergency room and to get this support, you know. Otherwise, I wouldn't be where I am today. (CRG06).

This breaking point creates a sense of having no alternative, as participants explain they "*don't have a choice anymore*" (RG17, CRG03), or are simply *"fed up"* (CRG01, CRG04).

In both groups, CSOs play a decisive role in motivating change. Some do so indirectly, as participants recognise the impact of their behaviour on loved ones: "*It was then that I realised I had to stop, that I'd gone too far. I'd dragged so many people into my problems*" (CRG01). Others act more directly, by confronting the person about the consequences: "[my brothers]… *told me that what I was doing wasn't right*" (RG17), or issuing ultimatums: "*I didn't have a choice, it was either I go get help or, well, I walk away*" (RG13).

Seeking help and entering treatment. In both groups, shame, guilt, and fear of judgment frequently lead individuals to isolation: "*the fear of being stigmatised too… I retreated, stayed at home, isolated*" (RG19). These emotions also prompt concealment—one participant "*hid everything*" (RG12), while another describes having "*managed to do whatever was necessary so that it wouldn't be noticed*" (CRG05). As a result, isolation and secrecy impede help-seeking, since CSOs often play a crucial role in facilitating entry into treatment, encouraging or insisting on seeking professional help: "*and that's when I was able to talk about it with my close ones, and it's them who pushed me to*

take the steps" (CRG08). Some take the initiative themselves by arranging medical appointments: "*it was my daughter who called to make an appointment for me*" (RG18).

Stage 5: constructing one's recovery goal

This stage comprises two main dimensions, which are raised by both groups. Yet, the discussion around controlled gambling reveals subtle differences between the groups.

Defining abstinence as the recovery goal from the start. After committing to recovery, participants must construct their recovery goal. Some in both groups immediately opt for full abstinence, acknowledging their inability to gamble in a controlled manner and perceiving an inherent risk of relapse: "*I need to totally quit gambling, because I don't feel capable… I'm impulsive and I know that if I start gambling again, I won't be able to stop*" (CRG03).

Redefining the goal: from controlled gambling to abstinence. Others initially aim for controlled gambling but later shift to abstinence after recognising that moderation is unsustainable, often undermined by the excitement of winning: "*when I set restrictions… it's that 'winning' side that's the most difficult to handle. I win, and then I tell myself 'well, go gamble again'… So I'm telling myself that, in the end, the best thing is total abstinence—that's my new goal*" (CRG07). Experiencing relapse is another common reason for this shift in goal: "*I had set myself a goal: to stop, but still allow myself to play once in a while* (bitter laugh)*… I ended up really stopping, but I would play in small bursts, and then it got going again. So my second goal, with* [my addiction therapist] *was to quit completely*" (RG16).

For some currently recovering gamblers, abstinence is constructed as the ultimate but initially unattainable goal. They set gradual objectives—reducing frequency or amount—to avoid discouragement:

> I set the bar too high, actually, compared to what I was capable of solving this problem… The goal was total abstinence, but the thing is that's incredibly hard, and I'm not capable of it right now, because it's been fifteen years that this thing has haunted me daily, several times a day, I think about it all the time, and quitting overnight is extremely difficult. (CRG08)

Stage 6: maintaining long-term commitment

This sixth step is the most data-rich in our study. It comprises four dimensions that, although all addressed by both groups, reveal important nuances depending on the group in question.

Developing commitment and personal investment. At the heart of recovery lies a sustained personal commitment—that is, a motivation to recover that participants construct and reinforce over time. In both groups, such motivation can be sparked externally, through the willingness to protect loved ones and repair relationships with them: "*with everything that happened, there's a lot to rebuild with my wife… it'll take however long it takes for things to get better, and it's up to me to do what's necessary*" (CRG05). Yet regardless of its initial source, what is ultimately at stake is active personal investment in the recovery process. Participants from both groups emphasise that therapeutic support—though often essential—is not a miracle solution in itself, and that its effectiveness depends largely on the individual's readiness to engage with it:

> In the end, despite all these people who are treating me and all that, I'm the only one who can drive this care and therapy, and it's up to me to do the work on myself. I can get help, sure, I can be supported, but it's a personal conviction. And it also involves help, but above all it's something visceral, something that's inside us, inside me, to heal myself… It's a fight, a fight against oneself. (CRG09)

Strategies and compromises. Recovery involves negotiating compromises for participants in both groups, such as grieving lost money: "*I have to accept grieving the money lost over these last 15 years of gambling, it's not easy to accept*" (CRG09). Participants must also relinquish gambling as their coping mechanism:

> Because in the evenings, that's really the time when—I don't know what happens—I just don't feel right… I just, I can't really manage my emotions properly during that time. And so, yeah, maybe 8 times out of 10, I catch myself thinking, "damn, I'd love to gamble just a little bit, just to relax or, or treat myself." But I don't give in, I don't give in. (CRG02)

Participants in both groups adopt strategies aligned with their recovery goal. Those aiming for controlled gambling set rules: "*then I learned not to scratch on the spot, to scratch at home*" (CRG04). Among those aiming for abstinence, strategies include avoiding triggers: "*I stopped going to the places where I used to play cards*" (RG17). They also distance themselves from gambling peers: "*so for my own protection, I cut ties with that whole circle, closed circles, people I knew, my poker acquaintances, I cut everything*" (RG19).

However, in both groups, pervasive advertising makes avoidance more difficult: "*there are always ads, things like that that make you think about it*" (RG20). Among currently recovering gamblers, the presence of gambling venues in their environment adds an additional layer of difficulty:

> At the end of the boulevard where I live, there's a gambling club that I had noticed for months and months… and it was really right on the path between my home and my workplace… so yeah, it was a problem in my daily life, day to day. (CRG09)

Financial safeguards represent another common strategy across both groups. Participants may limit access to funds through their bank: "*I had set up an overdraft ban, I didn't have any payment cards*" (RG14). They may also rely on their CSOs, such as by entrusting them with bankcards: "*I gave my bank card to my dad*" (RG11). Others delegate financial management to, or request financial monitoring from, their trusted ones: "*so now* [my brother] *has a proxy to control my account statements or see the expenses directly*" (CRG01). For both groups, these measures can help restore trust: "*regarding trust, I showed it by giving my card… I wanted to get rid of it anyway*" (RG18). However, they can

also feel infantilising for participants in both groups: "*when you're not in control of your payment methods… It's like having a childlike position. I'm 35, like a 12-year-old needing pocket money, going to get it from my mother*" (CRG09). In addition, for CSOs of currently recovering gamblers, this assistance can be burdensome: "*she's like my prison warden, my partner, even if it's not easy for her… she didn't really have much choice but to play this role*" (CRG08).

Some participants in both groups also use control measures like self-exclusion. These measures can be helpful for some: "*and the fact that I was banned… it also helped me a lot*" (CRG03). For others, however, they are mostly symbolic: "*I don't know if it really helped me… It feels good when you start something to tell yourself, 'well, I can do this, so I did it,' aligning a few small things to say 'well, I'm maybe moving forward a bit'*" (RG14). Indeed, participants in both groups identify gambling accessibility as limiting the effectiveness of these measures, as it is still possible to gamble in tobacconists[1] and on unregulated websites:

> There are tobacco shops everywhere, and even if you're banned from online gambling, it's on French sites, I mean there are plenty of ways… in any case it's a first step, but I know that if that was all there was, it wouldn't stop me from gambling. (CRG06)

Consequently, for currently recovering gamblers whose GD included sport betting, the main benefit of self-exclusion lies in protecting against impulsive gambling: "*spending less, even though back then I was still gambling in physical points.… Because online payment methods are so easy, you can spend huge sums in seconds, whereas going out, to the bank, withdrawing money, it's not the same process*" (CRG07).

Altogether, this dimension highlights the importance of internally imposed limits. Without such internal commitment, participants in both groups pointed out that they can always try to "*find an alternative to be able to gamble*" (CRG09) and that if they want to gamble again, they will "*find any solution*" (CRG05).

Maintaining commitment through a gradual recovery process. Recovery is a long-term process, as emphasised by recovered gamblers: "*it takes time… it really requires a lot of effort… It resolves over time, it's still long*" (RG14). Both groups describe the need for persistence despite initial difficulties: "*it was hard at the beginning*" (RG11). However, progress motivates participants from both groups: "*now I see that I have much fewer urges to gamble than before, and actually, that's encouraging*" (CRG06).

Sustained effort is reflected in consistent involvement in therapy and peer groups: "*sometimes, we're less motivated… well, you go anyway*" (RG18). This involvement appears crucial given that, for both groups, therapy facilitates recovery by offering attentive listening and advice: "*being listened to without being judged, that was good*" (RG13). It also provides guided reflection: "*someone external, competent… It confronted me with my behaviours, with what I was doing wrong*" (CRG06). Conversely, poor therapeutic alliance can be a barrier, especially for currently recovering gamblers, whether through relational discomfort: "*but I saw a psychiatrist, and it really didn't go well at all, actually, and that's why I almost gave up… I just felt really uncomfortable with him*" (CRG03), or perceived ineffectiveness: "*I'm tired of having to tell my life, my childhood, my stuff over and over so they can try to find causes… I feel like in the end it doesn't help, just talking, repeating, talking, repeating*" (CRG08).

Participants from both groups also interpret peer support as a key facilitator, offering shared understanding, breaking isolation and allowing perspective: "*talking with people, without judgment, who are in the same situation, learning what they do, seeing that we experience the same things*" (CRG03).

Support from CSOs is also essential for both groups: "*you can't do it alone… if you're alone and isolated, it's very complicated to get out of it*" (RG19). In both groups, CSOs are valued for their encouragement and non-judgmental support: "*my close friends supported me, they've always been there, they never judged me, on the contrary*" (RG15).

However, in both groups, not all participants can rely on such support due to relational barriers. Some experience misunderstanding: "[my parents] *didn't get it*" (RG20). Others report discomfort: "*it's kind of a topic* [my daughters] *don't really want to talk about*" (RG11). Guilt-inducing attitudes are also mentioned: "*I think my mom doesn't help because she makes me feel guilty all the time*" (CRG02).

Managing vulnerability and relapse. Recovery is a non-linear process for both groups, sometimes marked by relapse: "*I had stopped for a year, I relapsed, and I stopped again a month ago.*" (RG16). In both groups, this cyclical nature reflects enduring vulnerability to personal difficulties: "*I was devastated and I didn't know what to do, I was so sad that in the end, well, I started gambling again because it allowed me to escape*" (CRG02). Among currently recovering gamblers, this vulnerability is embedded in a vicious circle, as relapse affects morale through regret, guilt, and loss of hope: "*and there were times when, well, I lost hope, I thought, 'I won't make it, it's hard, why am I like this*" (CRG03).

Consequently, some participants in both groups interpret addiction as a lifelong condition: "*I'll never be cured of this. I fell into this addiction and it's something I'll have to fight all my life*" (CRG09). They live with a persistent "*fear of starting again*" (RG13). For recovered gamblers, however, "*fear of relapse*" (RG19) also serves as a motivational lever, and a reminder of the efforts and sacrifices made:

> For me, relapse—I don't even want to hear about it. For me, if I gamble again tomorrow, I've broken the three years… If I started gambling again tomorrow, I'd tell myself, "I've ruined three years, actually". (RG11)

To manage this risk, both groups develop relapse-prevention strategies. Some engage in reflective vigilance: "*it's myself I need to be most careful about*" (RG16). Others focus on introspective work: "*understanding where it comes*

[1]In France, tobacco shops are authorised points of sale for various gambling products including sports betting and lottery games.

from… That's what will make the difference so that I don't fall back into it" (CRG05).

Therapy supports these strategies. Currently recovering gamblers benefit from concrete techniques to identify and manage risk situations: "*having a few tools to identify moments when the urge is there, trying to find tricks to divert my attention and think of something else*" (CRG08). For recovered gamblers, therapy mainly provides space for support and encouragement: "[my addiction specialist] *told me, 'no, no, you're not relapsing, it's not a relapse. You've slipped back into gambling, that's all. You'll get through this.' She was very encouraging*" (RG16). Conversely, currently recovering gamblers often struggle with transparency after relapse. Some have difficulty being open with therapists: "[my addiction specialist] *told me, 'call me if you keep gambling'… I didn't tell her anything, I didn't call her*" (CRG10). Other currently recovering gamblers experience similar challenges with relatives: "*so I started gambling again, and then came the secrecy… When my loved ones ask, I say I've stopped, I don't gamble anymore*" (CRG08).

Stage 7: reclaiming autonomy and agency

This stage comprises four dimensions, mostly discussed by recovered gamblers. No specific facilitators or barriers are identified here.

Experiencing reduced compulsion and reclaiming autonomy. Participants in both groups gradually reclaim autonomy and self-determination as the mental grip of addiction loosens. Some frame this shift as a transition from slavery to freedom: "*I'm happy to regain a certain freedom, to be free. You're not free when you have an addiction, you're a slave*" (RG16). This freedom is reflected in the restoration of control over time and daily routines, previously dictated by gambling:

> Before, it was gambling that dictate my days… Now, it's changed a lot now anyway. Just the fact, well, that I call my brothers more often, that I go see them now, or take the train… walk by the sea, and then come back in the evening. But those were things I wasn't doing anymore… 'cause I was really in that mindset from the morning, well, that I had to go gamble'. (CRG01)

Regaining control over external triggers. Participants report greater control over external triggers. Both groups mention resisting advertisements: *"I don't pay attention to them anymore, they're just ads like before"* (CRG01). Recovered gamblers particularly demonstrate increased resilience across a range of challenging situations—resisting social pressure: "*I have friends who want me to gamble with them, but no"* (RG13), and enjoying sports without linking them to gambling: "*I've rediscovered the joy of watching football without thinking 'oh, I could bet on this'*" (RG14).

Re-establishing control over gambling behaviour. Another hallmark of regained autonomy, specific to recovered gamblers, is maintaining a controlled, detached relationship with gambling: *"I can go six months without buying a scratch card, and then maybe twice or three times a month… I'll stop by the newsstand, buy a magazine, and get a scratch card. But I'm not obsessed anymore*" (RG12).

Stage 8: rebuilding through recovery

This stage is divided into six dimensions. Except for identity renegotiation—specific to recovered gamblers—participants in both groups discuss all other dimensions.

From action to presence—constructing daily life and seeking fulfilment. Recovery extends beyond abstinence, involving rebuilding a balanced and meaningful life through active engagement. A key challenge for both groups is managing the void left by gambling, as inactivity can trigger rumination: *"you have to do things, because you need to keep your mind and your time busy… Going over the same things again and again, that's useless*" (CRG02). Initially used as coping mechanisms, new activities gradually acquire, for participants in both groups, personal meaning and foster purpose:

> So, boredom—to avoid it, well, you have to do activities, do things you enjoy… I'm not gonna start knitting a sweater just to tell myself, "well, at least I won't gamble this way" *(laughs)*. And it's an opportunity to, well, do things you enjoy. (CRG07)

For both groups, this engagement carries a eudaimonic dimension—pursuing meaningful activities that support well-being: "*I signed up for climbing again, I see my friends more often… now I feel calmer, I feel better*" (CRG06). It also contributes, for both groups, to rebuilding self-esteem: "*when I gambled, I had lost confidence… I'm in the process of regaining that… because I'm doing things that are rewarding*" (RG16). Recovery also involves, for both groups, cultivating a new form of hedonism. Participants emphasise *"simple pleasures"* (RG14, CRG06) that offer genuine enjoyment in contrast to gambling's artificial gratification:

> I'm starting to appreciate again little things I didn't appreciate anymore before, that I'm enjoying again a bit now. What do I like? Calm, I like watching animals, like birds, or listening to the radio. It's silly, but listening to the radio, that seemed pointless before. I needed fast things. (CRG02)

More broadly, regained proactivity signals a renewed engagement with everyday life for participants in both groups. They express this through revisiting abandoned interests: "*knitting, going out, going to the movies, museums, everything I used to do before*" (RG16). It is also reflected in deeper involvement in daily life and social interactions:

> After I stopped gambling, there was all that. Time, watching movies, being able to go for walks. Also taking an interest in things. When someone tells you something, you really listen, and you're interested in what they think. Before it was just "yeah yeah, okay, yeah." And nothing mattered except gambling. (RG11).

Rebuilding a sense of self through personal projects. For participants in both groups, reengagement extends beyond present-moment activities to encompass future-oriented goals. They gradually reconstruct the ability to envision a future once constrained by addiction: "*and there*

are a whole bunch of other things planned that I had stopped hoping for anyway, because I couldn't, financially I couldn't do them" (CRG01). As one participant puts it "*making new plans*" is synonymous with "*biting into life again, enjoying it*", and "*moving forward*" (RG19).

Alongside this reorientation comes, for participants in both groups a redefinition of their goals—adjusted to what individuals can genuinely achieve. Rather than "*delusions of grandeur*" (CRG09) fuelled by gambling, participants in both groups now pursue realistic, "*concrete projects*", "*without needing gambling to get there*" (CRG07)—such as moving house, *"a small, short-term project but that feels good" (RG19)*.

Rebuilding social connections. In both groups, this process of self-reconstruction encompasses interpersonal relationships. Several participants interpret socialisation as a cornerstone of recovery: "*I can't be fulfilled living like a hermit*" (CRG06). Breaking isolation often occurs, in both groups, through group activities and social outings: "*we shared some nice moments, we went out, from time to time… Those people got me out of the bubble*" (RG16). Such engagement also creates opportunities to meet new people: "*I go out more, I see more people, it allows me to open up more, to meet more people*" (CRG07). Reconnecting with pre-existing ties previously sidelined by gambling is another key step in both groups: "*I had a big, big period where I was really all alone… Today I've reopened myself to people I had shut the door on*" (RG19).

However, this re-engagement is not without challenges. Some participants in both groups, weakened by addiction and/or other comorbidities, struggle to break free from isolation: "*meeting people I don't know… no. I feel like I've still got too much baggage behind me to feel comfortable with others*" (RG11). Among recovered gamblers, this difficulty can be reinforced by self-stigma and fear of social judgement:

> It was the fear of meeting other people who knew me from before and had heard, wondering what they'd think of me and everything. And that lasted for years *(short silence)*. I didn't go see friends I had outside of gambling, I avoided them in case they'd see my former colleagues. I really isolated myself. (RG13)

In both groups, this social reconstruction also entails repairing social ties: "*I went to spend four days with my older brother this month, and the week after that I spent four days with my other brother too… I wasn't going anymore because, well, I couldn't afford it anyway*" (CRG01). Reclaiming familial responsibilities is another important aspect: "*now I take more care of my family… I realised that life wasn't just about me… there was family and everything. Because when you gamble you're selfish, it's pure selfishness*" (RG13). Among recovered gamblers, relationship repair also extends to couple dynamics: "*with my partner… we go out, we share a lot more things. That's good*" (RG20).

Remaining present despite addiction-related difficulties acts, in both groups, as a key facilitator in this process of social repair:

> It's also seeing in their eyes that despite what I did, despite the stupid things I did, the lies I told, well, that in their eyes, it hasn't changed, their opinion of me hasn't changed, and that's important. It's not easy every day because of course there are reproaches about what I made them go through… and I can't blame them, that's normal. But still, it matters that I feel that they love me, they love me despite my flaws and despite what I put them through. (CRG05)

A barrier shared across both groups nonetheless tempers this facilitator. Participants struggle with regaining CSOs' trust, which is eroded by addiction and especially by the lies it involves: *"addiction brings a lot of lies, and today, in the relationship I have with my family—they're there and everything—but I know it's going to take time before they really trust me 100% again"* (RG19).

Rebuilding social bonds also entails, in both groups, reassessing relational dynamics and prioritising authenticity and depth—qualities participants feel were absent from gambling-based friendships: "*When I had my gambling stuff, I didn't have any friends, you know… I had a few boyfriends like that, but now I've got a lot more friends, some proper ones and all*" (RG13). For participants in both groups, this process involves distancing from harmful or judgemental relationships: "*with those people I told you about, who judged me, well, I just cut it all off, said 'that's it'*" (RG19). Prioritising authenticity also involves selective disclosure about addiction: "*only my real best friends know*" (CRG06).

Financial stability and balance. In both group, the material dimension of recovery is central. For participants in both groups, regaining financial stability first requires repaying gambling-related debts: "*there's a debt file with the Banque de France, it's in progress and I've been repaying it for two and a half years already*" (RG11). In both groups, debt repayment can itself become a barrier when it creates financial strain in daily life: "*what's holding me back is that I'm repaying my debts… when I've paid everything, I have 300 euros left in the bank account… that's tight, I can't afford big expenses"* (CRG01), and constrains future plans: "*no more holidays, no more big trips or anything like that. Because I had spent way too much money*" (RG20). Across both groups, CSOs often play a key role by offering interest-free loans that help stabilise participants' situations: "*since my brother's financial help, my bank account is positive again*" (CRG01).

Debt repayment also holds symbolic value in both groups, marking tangible progress: "*putting a repayment plan in place also means telling yourself 'okay, now you're really in a healing process'*" (RG20). For recovered gamblers, it can also carry moral significance: "*they kept the rent debt so that the landlady could get her money back, which I'm actually glad about. She'd done nothing to me*" (RG11).

Beyond debt management, currently recovering gamblers describe learning to prioritise essential expenses to avoid new debt: "*I pay all the bills as soon as I get my salary… That's my technique to avoid falling back into the impossible spiral*" (CRG07). For both groups, this regained control

gradually opens up space for new possibilities, such as rediscovering modest pleasures:

> Eventually, I'm going to get back to a financial situation where I can afford, you know, little pleasures I wasn't allowing myself anymore. Buy myself some clothes, something simple, or even just have lunch at a restaurant—not even talking about fancy meals, but at least, you know, going out with friends. (CRG01)

It also involves saving for future projects: "*I opened a savings account and started saving for bigger projects than just going to the cinema. For example, my washing machine broke*" (RG16).

More broadly, participants in both groups reconstruct their relationship with money: "*in the end pleasure comes from the fact that you can't just buy it. If we're going to South America in three years, we'll need to save for it, and I like that. It's about going back to that value: you only get what you work for*" (RG14).

This shift contributes, for participants in both groups, to broader well-being, replacing constant financial stress with a sense of security: "*not being scared at the end of the month anymore, wondering how I'm going to pay everything back… That feels good*" (CRG05). A sense of peace of mind that deepens as repayment nears its end: "*we're getting close to the end of this file… I feel more serene*" (RG12).

Rebuilding overall balance. Participants in both groups describe a broader search for balance. This includes, in both groups, the adoption of healthier lifestyle habits. Some mention improved appetite: "*I eat regularly again, I eat balanced meals*" (RG19). Others highlight better sleep: "*sleep is much better, because I used to have periods when I barely slept*" (CRG03). For participants in both groups, this quest for balance also unfolds on an emotional level. Some report reduced stress and a pursuit of serenity: "*I don't have that constant stress anymore*" (CRG06). Others emphasise increased positivity and optimism: "*I see the good side of things more often now*" (CRG07).

Despite these improvements, several barriers persist. In both groups, mental health comorbidities and emotional distress are recurrent issues: "*I've been depressed for so long that being in a good place is exceptional, but it never lasts long*" (CRG02); "*that's my bipolarity—I go up, I go down, and sometimes I go really low*" (RG17). Painful life events and past trauma can also resurface: "*I wasn't well at that time—I'd lost my husband a few years earlier it was very hard, and it's still very hard. Oh dear, don't make me cry* (nervous laugh)" (CRG10). In both groups, these difficulties can sometimes be alleviated through therapeutic support extending beyond addiction-focused care, as one participant illustrates: "*In '99, when I attempted suicide—these are subjects I can't talk about anywhere else… The only place I can talk about it is with* [my addiction specialist]" (RG18).

Closely tied to this emotional distress are feelings of regret and guilt, common to both groups. Participants speak of self-blame, being "*eaten up by guilt*" (CRG09) over their GD: "*you ruminate in the end, you ruminate, you ruminate, for a few years. It doesn't heal just like the guilt thing, you always have it*" (RG13). This guilt also concerns the difficulty of accepting the irreversibility of the harm caused:

> Because of the fact that anyway I won't be able to repair it, so I'll never be 100% recovered. I'll stop gambling for sure, but all the damage I caused, since I'll never be able to repair it anyway, for me I'll never be 100% recovered. (CRG01)

Another barrier arises when addiction extends beyond gambling. Some participants report co-occurring addictions: "*I've been into drinking for quite a few years… and I smoke joints*" (CRG04). Others describe substitution phenomena: "*I didn't have any way to gamble anymore… so my frustration shifted a bit to alcohol*" (CRG02). However, only recovered gamblers mention addressing these other addictions as part of their recovery: "*as for cigarettes, I only smoke at work now. My 2024 goal is to quit completely*" (RG19).

Ultimately, these efforts toward balance lead to what several participants construct as a "*normal life*" (CRG01, CRG03, RG14)—a life that is not perfect but whose difficulties are those of ordinary existence rather than addiction:

> I don't believe in black and white, I went from black to light grey, and then, I'm not going to go into white, but I'll go into a slightly lighter grey again, but after that, well, that's life, and life is complicated, I'll always have problems to deal with, I'll always have kids to manage, I'll always have a job, I'll always have people leaving… but I'll be, quote-unquote, living a normal life, and it's this normal life that's kind of been my leitmotif since. (RG14)

Identity renegotiation. This final dimension, mentioned only by recovered gamblers, concerns ongoing reconstruction of identity in the context of recovery —that is, "*finding* [oneself] *again, like before*" (RG20). For one participant, this return to self involves moving away from the negative identity shaped by guilt and addiction: "*I saw myself as a loser, and I was a loser. But now, no—I'm becoming* [my first name] *again*" (RG13). For another, it means reconnecting with the person he used to be socially: "*finding what I was before falling into addiction. Someone very open, I love people, I love sharing, and that's something I'd lost and that I want to get back*" (RG19).

Given the importance attributed to this reconstruction of identity, recovered gamblers mention barriers related to low self-esteem: "*it's going to take time before I regain 100% confidence in myself, because we lie to others but we lie to ourselves too, and that's hard*" (RG19). They also highlight difficulties in overcoming shame and fear of social judgement: "*even though I'm calm now, I still feel ashamed if someone were to say, 'well, you don't go to the casino anymore, like before,' or things like that. I'd feel ashamed*" (RG12).

Stage 9: post-traumatic growth

This final stage is structured around five dimensions. While all but one are mentioned by both groups, recovered gamblers provide more testimonies, offering greater depth and nuance.

From regained serenity to pride in the journey. This dimension, specific to recovered gamblers, involves a sense of serenity, culminating in their capacity to speak about their experience with detachment: "*it's not painful anymore when I talk about it, and I can actually talk about it*" (RG16). Beyond this sense of calm, participants also express pride in their progress: "*it's true that now, I can say I'm proud of what I've done because I started from something very serious, and now I've made a lot of progress in ten years*" (RG15).

Life-course and identity reconfiguration. For participants in both groups, addiction—despite its destructiveness—serves as a catalyst for reconfiguring life and identity. For some, GD and the recovery efforts provide the opportunity and motivation to rebuild their lives through constructive and purposeful actions: "*it was a factor that helped me. Maybe I would've stayed in that relationship I didn't like, in that routine—maybe I'd still be there… It's paradoxical, but sometimes it also has positive effects*" (CRG08). Some recovered gamblers frame their experience as a clear life-course reconfiguration—marking a separation between their "*before*" and "*after*" lives (RG12, RG16), and speaking of "*a second life*" or "*a whole new life*" (RG15).

Beyond this reconfiguration of life trajectories, recovered gamblers interpret their experience of addiction and recovery as a source of personal growth, leading to an ongoing renegotiation of identity meanings:

> It completely changed me, completely. Now, between the person who used to gamble and the person I am now, they're two different people, completely. (RG15)

Strengthening of close relationships. Positive changes extend to family relationships, strengthening ties despite initial hardship: "*before, I didn't get along with my older brother at all. And since that day, when he found out, when he knew about my financial situation, there was a radical change in our relationship… really positive*" (CRG01); "*it completely brought me closer to my sister*" (RG15).

Meaning-making and adjustment of life perspectives. Participants from both groups describe developing a more constructive and positive approach to life's circumstances. One currently recovering works to turn difficulties "*into a strength for the future*" (CRG09). Recovered gamblers interpret their experience as having enhanced their capacity to adopt a more constructive approach to life challenges: "*so now I've got this ability to face things, but with a different mindset*" (RG14), including greater perspective and positivity: "*I've never been someone who's super positive… going through this fight, doing this fight, it opened my eyes to a lot of things, and so now I just take life differently*" (RG19).

Turning the experience of addiction into support for others. Both groups use their personal experience into helping others. Some do so through research participation: "*if your work… can potentially help all those who'll be victims… then I hope this little input into science will contribute something*" (RG14). Others engage in prevention work with at-risk individuals: "*now that my thing is coming to an end, one day if I see* [my nephew] *gambling, I'll tell him, 'come here, I've got to tell you what happened to me'*" (RG13). Peer support is interpreted as a key avenue: "*and if next year they asked me to go speak at that group to help people, I'd do it, because it can help*" (CRG03). As one participant explains, sharing his story serves a dual purpose, providing mutual benefits:

> What I want now is to be able to share all that, with people who fall into it. If I can make my experience useful, because I think it'll also do me good to be able to share all this. (RG19)

Yet shame and fear of stigma can still hold some recovered gamblers back from speaking openly: "*I know other people who are kind of addicted too, and I tell them to slow down a bit, but since I don't wanna say why I'm telling them that—though maybe I could help them if I did—but I'm still scared of how people would look at me*" (RG13). Nonetheless, what emerges is a powerful narrative: addiction is not only addressed but also leveraged to foster identity reconstruction, strengthened social ties, and constructive engagement with others.

DISCUSSION

This qualitative study explored subjective experiences of recovery from GD through in-depth interviews with self-defined recovered or currently recovering gamblers. Using CGT (Charmaz, 2006/2014), we developed a theoretical framework organising recovery into nine sequential stages, each with constitutive dimensions and associated facilitators and barriers.

Some of these barriers and facilitators align with the Recovery Capital (RC) framework (Cloud & Granfield, 2008), particularly the positive and negative resources empirically documented in GD (Gavriel-Fried & Lev-El, 2018, 2022). Facilitators such as support from loved ones correspond to Social Capital and therapeutic alliance and peer groups to Community Capital; barriers such as cognitive distortions, emotional vulnerability, and isolation reflect Human negative recovery capital (NRC), relational barriers correspond to Social NRC, debts to Financial NRC, and gambling accessibility to Community NRC. However, participants' experiences encompass holistic well-being as intrinsic goals, going beyond the RC framework, which—while multidimensional—primarily conceptualises these dimensions as resources instrumental to behavioural outcomes (cessation or control of gambling). For instance, rebuilding trust, addressing loneliness, and managing comorbidities were valued not merely as relapse prevention but as essential aspects of social recovery and overall health. Furthermore, our processual analysis reveals dynamic and paradoxical conditions that a static, resource-based model cannot fully capture—such as social support acting simultaneously as facilitator and constraint, or negative consequences serving as catalysts for change.

Additionally, several stages of our theoretical model overlap with recovery from SUDs and severe mental illnesses (SMIs), consistent with shared components across addictive and psychiatric disorders (Davidson et al., 2008; SAMHSA,

2012). In particular, maintaining long-term recovery and reclaiming self-determination appear common to both addiction and SMIs (Anthony, 1993; Davidson et al., 2008; Davidson & White, 2007). Moreover, this processual theorisation supports the notion—observed in both SUDs and SMIs recovery—that recovery is a non-linear and dynamic journey (Anthony, 1993; Ashford et al., 2019; Davidson & White, 2007; White, 2007). However, the first stage of this model, coming to terms with gambling problems, is a cognitive-emotional shift distinctive to addiction recovery (Davidson et al., 2008). This moment of recognition, often precipitated by an unbearable accumulation of consequences, forms part of the broader process of "hitting bottom" described in GD (Nixon & Solowoniuk, 2006; Reith & Dobbie, 2012; Vasiliadis & Thomas, 2018) and SUD research (Kirouac, Frohe, & Witkiewitz, 2015; Laudet, Savage, & Mahmood, 2002), but rarely discussed in mental health recovery. Numerous dimensions identified are also shared across recovery from GD, SUDs, and SMIs. Renewed agency, reflected in individuals' acceptance of responsibility, aligns with a sense of *personal empowerment* in GD (Pickering et al., 2020), and parallels the empowerment concept within the CHIME framework for schizophrenia (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Similar emphasis on agency is found in personal recovery from bipolar disorder (BP) (Chirio-Espitalier et al., 2022). Rebuilding social connections—restoring authentic relationships and meaningful roles (Pickering et al., 2020; Reith & Dobbie, 2012; Vasiliadis & Thomas, 2018)—is central across these disorders (Davidson et al., 2008), aligning with CHIME connectedness (Leamy et al., 2011) and BP closeness components. Hope, fostered through peer support and the reactivation of future-oriented thinking, is another shared component (Chirio-Espitalier et al., 2022; Davidson et al., 2008; Leamy et al., 2011). Identity reconstruction was crucial: participants rebuilt self-esteem—often undermined by internalised stigma (Nuske & Hing, 2013; Pickering et al., 2020)—was rebuilt through identity reconstruction and by distancing from the "gambling self" (Nixon & Solowoniuk, 2006; Pickering et al., 2020).

This resonates with GD research highlighting identity disruption (Nuske & Hing, 2013; Reith & Dobbie, 2012) and parallels identity rebuilding in SMIs recovery, notably schizophrenia (Davidson et al., 2008; Leamy et al., 2011). Participants also re-engaged in purposeful activities, moving beyond merely filling time—an aspect similarly emphasised in SMI recovery (Davidson et al., 2008). This reflects a reorientation of values and priorities, and fosters meaning and growth, also present in schizophrenia and BP (Chirio-Espitalier et al., 2022; Leamy et al., 2011). Finally, supporting others illustrates how recovery processes can be leveraged across GD, SUDs, and SMIs (Davidson et al., 2008; Nixon & Solowoniuk, 2006; Nuske & Hing, 2013; Pickering et al., 2020).

Our findings also resonate with the Transtheoretical Model of Behaviour Change (TTM) (Prochaska & DiClemente, 2005) regarding progression from recognition to action and sustained change, but go beyond a purely behavioural focus by capturing meaning-making processes and identity renegotiation, including rebuilding through recovery and post-traumatic growth (White, 2007; White & Kurtz, 2006). This last stage reflected how addiction, rather than being merely a past struggle, became a catalyst for reconstructing identity and generating personally meaningful changes. Additionally, by identifying stage-specific facilitators and barriers, and distinguishing between the trajectories of recovered gamblers and those currently recovering, our theoretical model offers practical insights for clinical support that extend beyond the stage-matching intervention logic of the TTM.

Finally, *financial recovery* (Heiskanen, 2017) emerged as a GD-specific dimension and constituted an essential to daily functioning and regained autonomy. It marked the transition from instability toward a future-oriented life, characterised by renewed engagement in personal projects, social activities, and long-term goals—central elements of the overall recovery process (Pickering et al., 2020).

LIMITATIONS AND STRENGTHS

This study has several limitations. First, qualitative research inherently involves a tension between abstracting to propose a common theoretical model and preserving the uniqueness of individual experiences. Using the Weberian ideal type (Weber, 2011), we constructed a simplified and accentuated pathway to capture shared recovery patterns, while fully acknowledging the non-linear, deeply personal nature of the process—such an "ideal path" does not exist in a pure form in reality. Rather than attempting to reproduce each trajectory's uniqueness, we focused on identifying common stages, dimensions, and facilitators and barriers across participants, allowing the collective recovery process to be understood coherently. This abstraction was counterbalanced by enriching each stage with detailed components to retain idiosyncrasy. Including both recovered and currently recovering gamblers allowed comparative insights across recovery statuses.

Second, practical constraints limited the implementation of full theoretical sampling. Instead, purposive sampling with a predetermined comparative design (recovered vs. currently recovering) was used, which may have limited our ability to fully explore certain dimensions and conditions that emerged later in the analysis. Future research could adopt more flexible recruitment strategies for true theoretical sampling.

Third, as all participants were engaged in professional care, the nine-stage process may not reflect natural or self-help recovery pathways (Kushnir, Godinho, Hodgins, Hendershot, & Cunningham, 2018; Slutske, 2006; Slutske, Blaszczynski, & Martin, 2009). In addition, certain dimensions of recovery identified may be influenced by the type or quality of professional support received, rather than reflecting intrinsic aspects of GD recovery. However, this focus enhances the clinical relevance of our findings, offering insights directly applicable to treatment settings. By

concentrating on individuals in professional care, we strengthen the validity of our results within this specific context, offering clinicians a more tailored understanding of the recovery process observed in practice.

Fourth, although initial coding was conducted by a single researcher (AM), which may have introduced individual bias, this limitation was mitigated through rigorous collaborative sessions with all authors critically discussing and refining emerging categories, dimensions, and conditions, ensuring that diverse perspectives informed the analysis and consensus on the final theoretical model.

Fifth, prolonged participant observation, often recommended to enhance credibility, was not feasible given our research objectives and practical constraints. Member checking and formal reflexive journaling were not conducted, and no formal audit trail was maintained. However, trustworthiness was supported via reflexive work, triangulation, detailed documentation of analytic steps, and iterative discussions among authors.

Sixth, patient experts were not involved in designing the interview guide, reflecting practical challenges of engaging this population in collaborative research design. Additionally, participants did not provide feedback on the findings. During recruitment, many expressed discomfort with group settings, raising concerns about organising focus groups to discuss results. Nevertheless, the validity of our theoretical construction is supported by their rigorous grounding in empirical data, reinforced through illustrative quotations drawn from multiple interviews. Future research could consider involving patient experts in the design of interview guides and incorporating participant feedback on findings, as this would enhance ethical engagement, ensure the relevance of the questions, and further validate the theoretical models developed from lived experiences.

Seventh, a further limitation relates to the semi-structured interview format, as some questions may have been directive or potentially leading, possibly structuring participants' accounts in advance and influencing the findings. However, this approach also helped maintain focus on the research objectives and ensured consistent exploration of key topics.

CONCLUSIONS AND DIRECTIONS FOR FUTURE RESEARCH

A key finding of this study is participants' multidimensional perspective on recovery. While anchored in the medical model—focused on reduced gambling behaviour and freedom from its grip—participants also emphasised subjective and social dimensions, including financial stability, relationships, and overall well-being. These findings underscore the need for a holistic, patient-centred approach that captures the complexity of recovery beyond clinical criteria.

Both recovered and currently recovering gamblers reported experiencing all nine stages of recovery, indicating a shared pathway. Clinicians can use these stages to help individuals situate themselves in the recovery process and facilitate their progression, while accommodating individual variations. The identification of stage-specific barriers and facilitators offers practical resources for recovery-oriented services and public health strategies to support individuals in overcoming challenges and building on their strengths.

Recovered gamblers addressed a broader range of dimensions, particularly concerning self-determination and post-traumatic growth, suggesting these aspects may become more salient in advanced stages. This highlights that recovery, while non-linear, remains a progressive process, with certain dimensions becoming more accessible as individuals advance in their journey. Longitudinal research with extended follow-up periods could further illuminate how recovery unfolds over time.

While motivational interviewing and gambling-specific cognitive behavioural therapy (CBT) remain the gold standard in early phases—particularly for achieving gambling cessation—later stages may benefit from approaches such as Acceptance and Commitment Therapy (ACT), which foster psychological flexibility, promote detachment from painful thoughts and emotions, and embrace multiple aspects of the self. ACT appears promising for helping individuals reconnect with core values, strengthen self-determination, and build meaningful lives beyond gambling; it may thus complement gambling-specific CBT by targeting broader dimensions of recovery that extend beyond behavioural change.

It is noteworthy that only currently recovering participants reported difficulties with therapeutic support, underlining the need for more responsive and adaptive interventions. Greater involvement of CSOs and stronger promotion of peer support emerged as promising strategies, as participants consistently emphasised the crucial role of informal support networks throughout their recovery.

Finally, this study confirms the added value of qualitative research in exploring recovery from GD. Lived-experience insights offer a depth of understanding that quantitative methods alone cannot provide (Mansueto et al., 2024; Pickering et al., 2020). A multi-stakeholder approach is needed to develop a unified definition of recovery, providing clearer guidance for services and public health policy and ensuring more tailored support for individuals.

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Authors' contribution: Study conception and design: AM, GCB, JBH, MGB. Supervision: GCB, JBH, MGB. Participant recruitment: AM, MGB. Development of the interview guide and methodological tools: AM. Data analysis and interpretation: AM. Data validation/discussion of coding framework: AM, GCB, JBH, MGB. Drafting of the manuscript: AM. Critical revision of the manuscript: GCB, JBH, MGB. Funding acquisition: GCB, MGB. All authors had full access to all data referenced in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. All authors contributed to the final version and approved it for submission.

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