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Perceived stigma and self-stigma of problem gambling: perspectives of people with gambling problems

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ABSTRACT

Minimal research has investigated the stigma associated with problem gambling, despite its major hindrance to help-seeking and recovery. This study explored perceived stigma and self-stigma to examine stigmatizing beliefs held, how they may be internalized, coping mechanisms, and effects on help-seeking. In-depth interviews with 44 people experiencing gambling problems were analysed using interpretive phenomenology. Results revealed an overwhelming perception that problem gambling attracts acute public stigma and is publicly viewed as caused by personal failings. Participants had serious concerns about being viewed as 'a problem gambler', fearing demeaning stereotypes, social rejection, hostile responses and devaluing behaviours. Many participants internalized perceived stigma as self-stigma, with deleterious reported effects on self-esteem, self-efficacy, perceived social worth, and mental and physical health. Deep shame was a near universal emotion and exacerbated by relapse. Secrecy was the main coping mechanism used, with perceived and self-stigma found to act as major barriers to disclosure and help-seeking. The findings can inform the development of a valid understanding and conceptualization of problem gambling stigma. This is a prerequisite for effective stigma-reduction strategies to reduce public stigma and discrimination, and to lower perceived and self-stigma and increase the use of treatment services and other interventions by people with gambling problems.

Introduction

Stigma has been defined as an 'attribute that is deeply discrediting' that reduces an individual 'from a whole and usual person to a tainted, discounted one' (Goffman, 1963, p. 3), leading to the devaluation of his or her social identity in a particular social context (Crocker, Major, & Steele, 1998). Stigma can be related to a physical attribute (e.g. a disability or deformation), group identity (e.g. race or religion) or personal traits perceived to arise from blemishes of character (e.g. drug addiction, mental illness, problem gambling; Goffman, 1963). Most research into stigma has pertained to a range of mental disorders. This research has identified stigma as the major challenge facing mental health

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(Hinshaw, 2006) and to engagement in mental health treatment (Corrigan, 2004). Various theoretical models have therefore been developed to explain different aspects of stigma, such as why (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Jones et al., 1984; Scheff, 1966; Weiner, 1986; Weiner, Perry, & Magnusson, 1988) and how (Link, Yang, Phelan, & Collins, 2004) it is created.

Little research has specifically investigated the nature of stigma associated with problem gambling, a condition 'characterised by difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community' (Neal, Delfabbro, & O'Neil, 2005). This is surprising, given that stigma and shame have been identified as major barriers to help-seeking for problem gambling (Gainsbury, Hing, & Suhonen, 2014; Hodgins & el-Guebaly, 2000; Pulford et al., 2009; Rockloff & Schofield, 2004; Tavares, Martins, Zilberman, & el-Guebaly, 2002). At the time of writing, only five peer-reviewed publications have focused specifically on problem gambling stigma: a review identifying numerous gaps in knowledge and future research directions (Hing, Holdsworth, Tiyce, & Breen, 2014) and four empirical studies, all with samples restricted to university students (Dhillon, Horch, & Hodgins, 2011; Feldman & Crandall, 2007; Horch & Hodgins, 2008, 2013). Thus, little is known about the public stigma attached to problem gambling, how it is perceived by people with gambling problems, and the self-stigma they may experience.

Public stigma is the reaction of society to stigmatized individuals based on the formation of negative attitudes towards the stigmatized population (Corrigan & Shapiro, 2010; Corrigan & Watson, 2002a). Public stigma can be manifest in the attitudes and behaviours of individuals towards groups and individual people with the stigmatizing condition, in the general social norms within a particular social context, and reflected in institutional policies and practices that restrict opportunities of those with the stigmatizing condition (beyondblue, 2015). Public stigma is therefore a social process that distinguishes between those considered 'normal' and those who are not (Rusch et al., 2005). Stereotypes, prejudices and discrimination are central components (Corrigan & Watson, 2002a). One prominent conceptualization of how public stigma is created depicts it as an integrated process involving labelling, stereotyping, separating (social distancing), emotional reactions, and status loss and discrimination (Link et al., 2004). The degree of public stigma applied appears dependent on several perceived dimensions of the attribute or condition. These dimensions can include the ease or difficulty of hiding it (concealability), perceived extent of individual responsibility for the attribute (origin), whether it can be reversed over time (course), how disruptive it is to interactions with others (disruptiveness) and how much the attribute elicits responses of disgust/revulsion (aesthetics) and of fear/danger (peril) (Jones et al., 1984).

The four empirical studies on problem gambling stigma have focused on various aspects of its public stigmatization. Feldman and Crandall (2007) found that pathological gambling was the 13th most stigmatized condition amongst 40 mental disorders. Horch and Hodgins (2008) found that disordered gambling was more stigmatized than cancer, but equally as stigmatized as alcohol dependence and schizophrenia. Dhillon et al. (2011) observed that the stigmatization of problem gambling varied with the culture of both the stigmatizer and the stigmatized. Horch and Hodgins (2013) identified a range of negative stereotypes associated with 'problem gambler' and 'gambling addict', with some variations for each label. These studies suggest that problem gambling attracts considerable public stigma relative to other health conditions, but that the degree of stigma depends on who is doing the stigmatizing and who is being stigmatized.

Perceived stigma is the awareness of public stigma, or a belief that others have passed judgment and hold stigmatizing thoughts or stereotypes about a condition (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, Watson, & Barr, 2006). One study of over 80,000 participants across 16 countries concluded that perceived stigma is frequently and strongly associated with mental disorders worldwide (Alonso et al., 2008). Whether accurately interpreted or not, perceived stigma has been associated with negative outcomes when held by people with the stigmatizing attribute, including lower self-esteem; adherence to treatment; social adjustment and quality of life; and higher work, role, and social limitations (Alonso et al., 2009; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Perlick et al., 2001; Pyne et al., 2004; Sirey et al., 2001).

Perceived stigma appears very high amongst people with gambling problems. A (non-peer-reviewed) study (Carroll, Rodgers, Davidson, & Sims, 2013) found that participants with gambling problems invariably expected others to think badly of them, which discouraged help-seeking due to fear of being labelled 'a problem gambler', of being judged by treatment providers and of others finding out they were attending treatment. However, the effects of perceived stigma vary. While some people react with anger, others are indifferent, and some may internalize these negative attributes as self-stigma (Corrigan & Watson, 2002b).

Self-stigma is the prejudice which people with a stigmatizing attribute turn against themselves, where they come to believe and internalize negative public stereotypes, resulting in diminished self-esteem, self-efficacy and perceived social worth (Corrigan & Watson, 2002b; Scambler, 1998) and behaviour modifications to cope with their 'spoiled identity' (Goffman, 1963, p. 3). These coping mechanisms can include secrecy through hiding the condition, withdrawal from social interaction and support, educating others about the condition, challenging prejudice and discrimination, and cognitive distancing from the stigmatized group (Link et al., 2004). Hing et al. (2014) have suggested that secrecy is the most common way of coping with the self-stigma of problem gambling.

No peer-reviewed studies have directly examined self-stigma associated with problem gambling. An unpublished doctoral thesis examined how individuals seeking treatment for problem gambling navigated self-stigma in relation to professional stigma (stigmatizing attitudes, labels and categorizations by treatment providers; Anderson, 2014). Findings revealed the considerable burden that professional stigma places on clients, and how it can impede treatment and recovery by limiting client disclosure and prompting some to withdraw from therapy. Carroll et al.'s (2013) study illuminated some psychological effects of self-stigma. The 30 interviewees with gambling problems rarely referred to 'stigma'; instead, 'shame' was the most commonly used term to describe their emotions, along with 'embarrassed', 'weak', 'stupid', 'guilty', 'disappointed' and 'remorseful' (Carroll et al., 2013). These feelings appear to reflect loss of self-esteem and perceived social worth, as found for other mental conditions (Corrigan, 2004; Watson, Corrigan, Larson, & Sells, 2007).

While prior research into problem gambling stigma has provided valuable insights, the experience of those most affected remains largely unexamined. Therefore, the aim of this study was to explore perceived public stigma and self-stigma amongst individuals with a gambling problem to examine the stigmatizing beliefs they hold, how these beliefs may be internalized, the stigma coping mechanisms they use, and effects on help-seeking. Achieving a better understanding of problem gambling stigma may eventually increase strategies to create more tolerant public attitudes, reduced stigma, higher rates of help-seeking, and improved recovery prospects.

Table 1. Age and sex of participants.

Age	Male	Female
18–24	6	0
25–34	9	4
35–44	7	0
45–54	3	5
55–64	3	4
65 or over	0	3
Total	28	16

Methods

Approval for this study was obtained from [withheld for anonymity] Southern Cross University Human Research Ethics Committee. As a qualitative approach suitable for research with marginalized groups of people, phenomenology was used to generate shared meanings of experiences implicit in original descriptions of experiencing a phenomenon (Creswell, 2007; Moustakas, 1994). Lengthy semi-structured interviews generated rich detailed descriptions and enabled exploration of what is important to participants (Geertz, 1983; Smith, Jarman, & Osborn, 1999) in their experience of problem gambling stigma.

Recruitment and sampling

Phenomenological studies require only small samples because it is the in-depth quality rather than quantity of data that enables insightful analyses. Participants were recruited through a prior survey, conducted by the authors, of 203 Australian adults who had recently experienced a gambling problem. This survey included only people who self-reported experiencing a gambling problem in the previous three years. Recruitment emails were sent to 395 eligible people on our research centre's database of previous survey respondents who had consented to receive invitations to participate in future research. Thirty-six emails bounced back and 117 completed responses were received for a response rate of 32.6% from this population. Google advertisements were used from 5 June to 28 July 2014 and gained an additional 86 responses. Respondents received a AU$20 shopping voucher for completing the survey. A survey question invited respondents to participate in a telephone interview about problem gambling stigma. Amongst the 58 survey respondents who agreed to an interview, 44 interviews were achieved, with the remainder being non-contactable despite multiple contact attempts.

Participants

Amongst the 44 interviewees, 28 were males, with about two-fifths of participants aged less than 35 years (Table 1). Twenty-three participants described their ethnicity as Australian, with the remainder from backgrounds including Indian, English, Serbian, Greek and Asian.

Gaming machines, horse race betting and online sports betting were reported to have caused most gambling problems amongst males, although many discussed multiple problematic forms. Seven males had experienced gambling problems for less than 2 years, 10 for 2–10 years, 5 for 11–19 years, and 6 for over 20 years. Most females were aged over 44 years. All reported gaming machines as most problematic except one who reported horse race

betting. Three had experienced gambling problems for less than 2 years, 9 for 2–10 years, and 3 for over 20 years (1 unknown). Fifteen described their ethnicity as Australian and one as Greek. Thus, female participants tended to be older and to have experienced gambling problems for longer; males were more likely to have problems with wagering, and women with gaming machines.

Procedure

All recruits were sent a participant information sheet, informed consent form, and the interview questions (to enable the gathering of more considered responses from the interviewees). All interviews were conducted by telephone by 1 of 2 clinical psychologists, lasted 30–60 minutes, were digitally recorded and later transcribed. Participants received a AU$50 shopping voucher as reimbursement for their time.

Interview schedule

The interview schedule contained four main sections: (1) demographics and gambling of participants; (2) perceived public stigma, including how problem gamblers are perceived to be viewed by others and experiences of stigmatizing attitudes and behaviours; (3) self-stigma, focusing on participants' feelings about having a gambling problem; and (4) coping with stigma and effects on help-seeking behaviour.

Analysis

Interpretative phenomenological analysis was used to generate deep insights and understandings into how individuals make sense of the phenomenon being studied, including the meanings and perceptions they place on their particular experiences (Smith et al., 1999). Themes were identified from participants' accounts, and connections made between themes to group them in a meaningful way. Trustworthiness of the data was enhanced by professional transcription of interview recordings, and checking transcriptions against recordings and for inconsistencies in individuals' responses (Stiles, 1993). The interviewers also periodically reflected their understanding to participants during interviews to check accuracy of interpretation, in a 'recycling' process (Atwood & Stolorow, 1984). Trustworthiness of the interpretation was enhanced by a second researcher reviewing all transcripts to ensure that salient themes and sub-themes had been faithfully captured, and that no important themes or sub-themes had been overlooked in the first analysis. Validity was also enhanced by using a range of participants' quotes to support interpretation, tagged below by participant number, gender and age range, respectively. Results are discussed as they are presented to position them within theoretical models of stigma and in relation to previous research.

Results and discussion

The analysis identified numerous themes and sub-themes, summarized in Table 2, and these are included as subheadings or underlined in the analysis below.

Table 2. Themes and sub-themes in results.

Perceived public stigma: stigmatizing beliefs held by participants	*Coping with stigma*
• Perceived origin of problem gambling and other dimensions • Labelling and stereotypes • Separating through social distancing • Emotional reactions • Devaluation and discrimination	• Secrecy • Delaying disclosure • Reluctant to self-acknowledge their problem • Diminished self-efficacy • Courtesy stigma • Relapse appeared to worsen self-stigma • Cognitive distancing
Self-stigma: internalization of stigmatizing beliefs by participants	*Influence of stigma on seeking formal help for problem gambling*
• Lowered self-esteem • Physical health problems • Eroded self-efficacy • Shame	• Self-exclusion • Peer support groups • Formal counselling • Online and telephone support

Perceived public stigma: stigmatizing beliefs held by participants

Perceived origin of problem gambling and other dimensions

When asked how they perceive others to view 'problem gamblers', it was clear the interviewees perceived an acute public stigma. Participants overwhelmingly considered that the public views 'problem gamblers' in a highly negative light. They used strongly emotive descriptors including 'stupid', 'foolish', 'weak', 'untrustworthy', 'secretive', 'losers', 'self-indulgent', 'lacking self-control', 'irresponsible', 'pathetic', 'desperate', 'lacking intelligence' and 'no hopers'. These terms suggest a belief that others view 'problem gamblers' as being entirely to blame for their own situation due to failures of character such as lack of control, low intelligence, dishonesty and selfishness. Consistent with attribution theory (Weiner, 1986), greater stigma occurs when a condition's origin is believed to be due to an individual's own actions, as opposed to biology or accident as is more commonly perceived for physical disabilities and mental health conditions such as schizophrenia (Jones et al., 1984). One participant relayed this perceived public view of personal responsibility for problem gambling, that it could be cured simply by abstaining from gambling, which was just a matter of self-control:

> They'd say, 'Oh, all you've got to do is stay away [from gambling].' They look at it as being a weak person that is a problem gambler, someone that's got no control over what they're doing. (48, F, 65+)

A few participants recognized that their own views about the origin of problem gambling had changed as they moved from controlled gambling to viewing themselves as 'a problem gambler'. One explained how his thinking had shifted from seeing problem gambling as an individual's own fault, to a more sympathetic perspective, suggesting that greater understanding of problem gambling may lead to more tolerant attitudes:

> I used to think a problem gambler – it was their own fault and what they thought they were doing, and why on earth didn't they just stop it and how could they possibly do what they were doing to themselves and for their family and others? That view has changed as a result of my own experiences. I am now understanding that it's not necessarily something that's within control. So I have a great deal of sympathy. (25, M, 55–64)

Studies have reported addictions to be more negatively perceived than other mental illnesses (Corrigan et al., 2005; Link et al., 1989; Martin, Pescosolido, & Tuch, 2000), with drug addiction generally more highly stigmatized than alcohol and gambling addictions, which have

been found to attract similar levels of stigma (Arbour-Nicitopoulos, Faulkner, Paglia-Boak, & Irving, 2010; Horch & Hodgins, 2008). Addictions tend to be highly stigmatized because affected individuals are perceived as blameworthy for their disorder (Angermeyer & Dietrich, 2006), despite having impaired control over their addictive behaviour. Poor understanding of the strength of the addiction experienced by people with problem gambling was alluded to by other participants as a source of stigmatization in the general community:

> It's really just those people that don't gamble, don't understand that it is an addiction. So they're the ones that stigmatise them … they tend to put a stigma on it rather than understand the problem. (33, M, 25–34)

> To just assume that someone can just stop without help; I don't think that that's fair to expect people to snap out of it. (9, M, 18–24)

There was little evidence of beliefs that reflected other potentially stigmatizing dimensions of problem gambling; concealability, course, aesthetics and peril (Jones et al., 1984) were not revealed as important in shaping other people's stigmatizing attitudes towards problem gambling. Some participants, however, alluded to a belief that others view problem gambling as highly disruptive to social interactions. One commented:

> They think that they're just wasting their time in the venue. They think they're thieves. They're liars. They have no life. They have no family. (16, M, 18–24)

Labelling and stereotypes

The preceding beliefs also reflect stereotypes attached to the label of 'problem gambler'. Scheff (1966) argued that labelling an individual's behaviours as a condition triggers stereotypes and social rejection, a view also advanced for problem gambling (Castellani, 2000; Cosgrave, 2008; Reith, 2007; Reith & Dobbie, 2012). Similar to participants' views, a recent study found that the most common stereotypes are that 'problem gamblers' are compulsive, impulsive, desperate, irresponsible, risk-taking, depressed, greedy, irrational and antisocial (Horch & Hodgins, 2013). Stereotypes are efficient ways of categorizing and organizing information about different social groups, based upon collective opinions about group members (Judd & Park, 1993; Rüsch et al., 2005). Thus, labelling individuals as 'problem gamblers' is accompanied by a set of assumptions about their character. One participant alluded to the labelling and stereotyping process in expressing his fear that he was now completely defined by his condition:

> It makes you think that they're looking at you and seeing that weakness and perhaps that's all they're ever going to see after that and they're never going to be able to see you as successful or well-rounded and everything else. (4, M, 35–44)

Other participants recognized this stereotyping and were resentful that it obscured their good and 'normal' qualities:

> It is a stereotype that problem gamblers are incapable of being a normal human. (33, M, 25–34)Some which generalise gambling into like one category and it's like them all … I generally disagree with that because I know that I'm a good person. (41, M 18–24)

Separating through social distancing

Labelling also emphasizes difference and implies a separation from 'them', who are perceived as fundamentally different from 'us' (Rusch et al., 2005). Reflecting this separating component during stigma formation (Link et al., 2004), participants recognized that people

generally prefer to maintain social distance from people experiencing problem gambling. Two comments reflect this desire for social distance both from 'problem gamblers' in general and also from participants as individuals:

> They don't want to make friends with them. They keep their distance from problem gamblers. (8, F, 55–64)

> They either can't be bothered with you or they just think you are an idiot. (48, F, 65+)

Emotional reactions

Link et al. (2004) argued that the process of labelling, stereotyping and social distancing is likely to be accompanied by emotional responses that affect subsequent behaviours (such as helping versus punishing). Sympathy and pity are more likely when a condition's cause is perceived as outside of individual control, and irritation and anger when perceived as the person's own fault (Jones et al., 1984; Weiner, 1986; Weiner et al., 1988). Anxiety, apprehension and fear can be expected when the condition is perceived as dangerous (Corrigan et al., 2003). About half the participants had not disclosed their gambling problem and so had not experienced others' emotional responses directly. Amongst the rest, about half encountered supportive reactions, but others received negative responses, with comments about wasting money or doing something better with life being common. Other comments were that 'he thought I was stupid playing the pokies' (32, F, 45–54) and 'it's all in the genes; you'll end up like your grandfather' (28, M, 25–34). Another related that 'I've had friends tell me I was selfish for gambling 'cause I should be spending my money on my son' (5, M, 18–24). Another conceded that his 'family judged me, but had every right to' (35, M, 35–44). Irritation, contempt, anger and blame were apparent in the responses recalled by two participants:

> I thought they'd support me but they haven't … I'll say, 'Look, I enjoy going to the club', and then I can see the look of disdain in their faces. You know, can't you do something better like clean your house instead of spending all the time at [the club]? (8, F, 55–64)

> My best friend … reacted really angrily because he felt like I was wasting my life and my money and my current situation with my family. And I thought he would've been more sympathetic to my situation, but he reacted angrily to me. It shocked me! (51, M, 35–44)

Some participants, however, were surprised to encounter more positive, supportive and sympathetic reactions from family and friends than they had expected when they disclosed their problem, for example:

> I thought my parents would be really angry and judgmental because they're very religious but when I did tell them, they were nothing but supportive and they got me help with a counsellor and just stood by me. (9, M, 18–24)

Devaluation and discrimination

Public stigmatization also provides a rationale for devaluing and discriminating against stigmatized people, which is the last step in Link et al.'s (2004) conceptualization of public stigma creation, after labelling, stereotyping, social distancing and emotional reactions. While some respondents avoided judgment through hiding their problem, more than half had felt judged by others because of their gambling. It was difficult to know whether these perceptions of devaluing judgments were well founded or erroneous. A few participants were able to describe actual experiences, but most could talk only about a general impression

or fear, such as those below who felt that they were being watched and judged by family, friends, and patrons and staff in gambling venues:

> When I'm not there, they say something else. (21, M, 35–44)

> I often feel people maybe are watching me … that's only my own feelings, it's not that anyone has said anything to me. (43, M 45–54)

> You throw 50 after 50 in, and there's a little old lady betting 25 cents next to you, and she's watching you betting $50 a hit, so – yeah. She's definitely judging you. (16, M, 18–24)

Perceived loss of status was keenly felt by some participants, with two maintaining that others consider people with gambling problems to be the 'scum of the earth' (41, M 18–24) and 'lower citizens' (4, M 35–44). Other research participants related more personal experiences of belittlement when hearing comments such as 'he's just a no hoper, he's no good, he's got no money, he can't come out for a beer' (16, M, 18–24) and 'you're just a lonely pokie lady' (46, F, 45–54). Two others related how they had felt demeaned:

> Like being looked down on, almost as if it was criminal. (51, M, 35–44)I was a regular at a particular place and obviously I'd continually lost there … the staff … act like they're better than you … they look down on you. And so, when they're going to serve me, like for a drink …it's just like 'oh, just hurry up. Get it and go'… I didn't go back after that actually because you're having to deal mentally, to try to win your money back without having to deal with people thinking you're below them. (51, M, 35–44)

Actual examples of discrimination were rare, as most participants had not widely disclosed their gambling problem. One related the following incident:

> Well, this was the most embarrassing thing that happened to me. When I self-excluded myself from one of the clubs, my girlfriend's husband was a security guy who'd go and pick the money up. And they must have photos up in the office, and she said to me, 'So and so saw your photo in the office of the club that you self-excluded yourself from.' I just felt terrible. But he shouldn't have even mentioned that because that's a privacy issue. So I was really not happy about that. I rang up the club and I felt that they should not have those photos on show for people to come in from outside to be seeing … And I felt in that case, I was being discriminated against because I felt that they didn't care. (48, F, 65+)

Following an experience of judgment or discrimination, many participants recalled feeling angry, defeated, inadequate, surprised or just terrible. Three interviewees, however, maintained that they did not care as they were 'thick skinned', 'tough' or 'I simply laughed it off' (36, M, 55–64), although it is possible that these claims reflect a certain bravado used as a coping mechanism to hide deeper feelings of shame. These three participants were all male, ranging in age from 35 to 64; however, further research is needed to ascertain whether reported resistance to negative judgment is gender-based and to identify other influential factors. For some participants however, perceived stigma appeared to be internalized as self-stigma.

Self-stigma: internalization of stigmatizing beliefs by participants

Perceived public stigma can result in a spoiled social identity which may adversely impact on subjective identity; the resulting self-stigma then affects what stigmatized people think about themselves (Goffman, 1963). When participants were asked how having a gambling problem made them feel, the impact on their self-image was striking, reflecting the diminished self-esteem, self-efficacy and perceived social worth that accompanies self-stigma

(Corrigan, 2004; Watson et al., 2007). Most participants described feeling 'weak', 'stupid', 'worthless', 'bad', 'ashamed' and 'embarrassed'. Emotions such as anger and annoyance (at themselves), as well as guilt, dominated. Feeling 'surprised', 'disgusted', 'scared', 'incomplete', 'anxious', 'saddened' and 'uneasy', and experiences of loss of dignity and 'crying inside' were also mentioned.

The vast majority of participants felt that their self-esteem had been affected, as explicitly noted here:

> Makes me feel very depressed. You know, it lowers my self-esteem. (46, F, 45–54)

> I can go really good all day and just exercise and then if I decide I'm going to go to the club that night, then I feel that when I come home I will binge on chocolate or whatever else, because my self-esteem just – I've got none. (48, F, 65+)

For some, the stress and depression associated with feeling badly about their gambling had manifested as physical health problems:

> I feel sick in the stomach. I dry retch because I'm that sick. (8, F, 55–64)

> You turn to hide away a bit more and avoid conflict, and you don't stand up for yourself. And physically, it's hard. It's – I get a lot of stress and stomach pain or build up a lot of stomach acid. (33, M, 25–34)

> Depression. Yeah. It's – well, physically, it's like in waves … it has caused me massive weight gain and laziness, fatigue, just as a side effect to depression. (51, M, 35–44)

Self-descriptions of feeling 'defeated', 'debilitated', 'isolated', 'restricted' and 'trapped' reflected participants' feelings of eroded self-efficacy in relation to resolving their gambling problem. Other participants alluded to their diminished self-worth that manifested as shame. For example, two said:

> I feel less of a person that I can't control something. (2, M, 35–44)

> Sick, ashamed, angry and guilty. (8, F, 55–64)

However, whether the shame that typically accompanies problem gambling is always an internalization of public stigma as self-stigma, or instead occurs because the behaviour violates internal values is unclear; and the literature presents conflicting views about whether shame primarily emanates from external or internal sources (Carroll et al., 2013). To try to untangle this relationship, participants were asked if their negative feelings about having a gambling problem were due to perceptions, comments or behaviours of others or how they viewed themselves. This was a complex issue, with many discussing that they viewed themselves in this way, but that what they perceived others to think compounded these feelings. A few interviewees either specifically considered these emotions as emanating from self-judgment or did not seem to care what others think. For example:

> It made me feel bad about myself because I knew that it was silly and I knew that it was pointless. (14, M, 45–54)

> It was just more about correcting a weakness, I don't really worry too much about the criticism. (36, M, 55–64)

> So a lot of the time I don't actually think about what others think about me because I can hide it, keep it to myself. It's probably just me judging me, rather than them judging me. (4, M, 35–44)

In contrast, many participants were more concerned about how others saw them (particularly family and friends), or would see them if they disclosed their problem. One commented:

> A lot of it is to do with how others perceive you and what you think they think of you because of it. (9, M, 18–24)

Some participants described how the source of their shame had changed. For example, one participant explained:

> It used to be about others but now it's how I perceive myself, because after a while I thought 'Oh, what they think doesn't matter', but I can't get away from what I feel about myself. (48, F, 65+)

The secretive nature of their problem meant that most participants did not receive direct judgment or stigmatization from those around them. However, strong feelings of self-stigma were very apparent for most participants. A few considered that their gambling did not affect their physical or mental well-being at all, reflecting an absence of self-stigma, such as:

> It never affected me physically at all. And, mentally, I've sort of a bit of a 'screw you' attitude or do whatever I like. It's my money. (36, M, 55–64)

Coping with stigma

People's desire to manage their identity by hiding shameful problems, to protect themselves from being shunned by society and significant others, explains why many individuals keep a gambling problem hidden (Carroll et al., 2013). Secrecy is a common coping mechanism for stigma (Link et al., 2004) and was the most apparent strategy used by research participants. All participants acknowledged having a gambling problem, but about half said they had not and would not admit it to others due to fear of rejection, feeling it was too shameful and because no one would understand. Others recalled delaying disclosure, such as one interviewee who related how ashamed he felt:

> It took a long time for me to actually come forward and kind of admit that I had a problem. Yeah. It obviously took a long time to get over that. The shame, as you say, there's the shame of it. And just to be able to come out and say it. (27, M, 25–34)

People may be reluctant to self-acknowledge their problem because identifying as 'a problem gambler' is likely to discredit their identity, contradict their desired self-concept, and erode dignity and self-worth (Snow & Anderson, 1987). Two participants alluded to this when explaining why they had not told their families:

> I don't tell them anything and I have a million and one excuses of where the money went or why I've got, how I got this, and why this is not paid. So it's basically being devious because I don't want them to look at me and think – I don't even want their pity, you know, I just want them to think of me, same as others would be. (48, F, 65+)

> Because I don't like to admit that I have a problem and, you know, that would be admitting to my husband that I do have a problem. But I like to think that, you know, I can control it … but I know like next week when I've got my month's pay, I'll be like 'Oh well, I'll just go [gambling] for a little'. (32, F, 45–54)

The diminished self-efficacy that accompanies self-stigma, the 'defeatist attitude that gets into you' (28, M, 25–34), sometimes hindered moving towards recovery. One explained:

> I feel it made it a lot harder to get started [on recovery]. I don't know whether that was due to real external stigma or it's just my rejection. But I did struggle for months, maybe even a year, to actually talk to other people about it. And that was definitely … my perception of the stigma. (50, F, 25–34)

Others participants did not reveal the full extent of their gambling to family and friends, while some significant others appeared to purposefully ignore the gambling problem due to their own embarrassment and shame, reflecting 'courtesy stigma' (Goffman, 1963):

> I think they're ashamed … they turn a blind eye and just, you know … ignore that there's a problem … it's a taboo subject. (8, F, 55–64)

Episodes of relapse worsened self-stigma and encouraged more secrecy for some participants. Many had relapsed at some point, and this was accompanied by feelings of self-loathing, listening to others telling them not to do it again, and finding it even more embarrassing to admit they had failed to stop gambling. Thus, some participants did not disclose their relapse to others, such as one who shared:

> It's harder too. It's a struggle because you just don't feel confident enough to be raising the issues, you relapsed, and all that … So it was more predicament and you go 'Oh, I really don't wanna be a joke or I don't wanna look like an idiot so I'm just gonna shut my mouth and hope it goes away'. (50, F, 25–34)

The interviews revealed minimal evidence of use of other forms of coping, such as withdrawal, educating and challenging (Link et al., 2001), although cognitive distancing was evident in delays in problem acknowledgement and avoidance of help services, as these would confirm the presence of a gambling problem to self and others.

The influence of stigma on seeking formal help for problem gambling

Self-exclusion

Coping with stigma through secrecy also extended to avoiding formal help. More than half the participants had never self-excluded, with most admitting that shame had deterred them. Some felt able to self-exclude online as this was more anonymous, but were unable to do this in land-based venues due to feelings of humiliation, shame, embarrassment, fear of being recognized and judged, and a general sense of their own weakness. Two participants explained how they had resisted self-exclusion because it would mean self-admittance of a gambling problem; however, one found online exclusion less self-stigmatizing:

> One of the things my wife wanted me to do was to self-exclude. For more than a year after it came out, I saw that as a sign of failure and it was an admission that I was not strong enough and not good enough and not the sort of person I wanted to be. That surely the goodness I can stop this without having to be prevented from going somewhere and having that sort of potential embarrassment … I did [self-exclude] in the end. And that was a pretty traumatic experience to be honest. (25, M, 55–64)

> In a venue – If I'd have done that … I would have felt that that I would have let myself down by not being able to deal with it myself … when you do this online business, you're not going to go to the public and say, 'Oh, I'm barred from . . .' Ultimately, I've just barred myself from these websites. (36, M 55–64)

Peer support groups

Very few participants had joined peer support groups. Most felt that such groups were simply not for them, due to reasons other than shame. Some explained that they were not very sociable, that there were no groups nearby and that attending a group reflected personal weakness in not being able to resolve the problem on their own. However, a few expressed a fear of being judged by group members, a sense of self-failure, and fear of disclosure and stigma, such as one who shared:

I didn't want to join . . . it's not just admitting to yourself, it's admitting to the world and then everyone is going to look at you different and you don't want that. (48, F, 65+)

Formal counselling

About half the participants had received formal counselling. Willingness to undergo counselling was sometimes apparent in spite of stigma:

I haven't really felt that that [stigma] affects going to see a counsellor because generally, once you get to that point, you need to talk to someone, and the stigma doesn't really bother you. (33, M, 25–34)

Some thought that counsellors would be supportive, despite expecting some judgment from them:

I know they'd be kind and supportive and they're there to help you, but everybody is judgmental in some way whether they realise they do it or not. (1, F, 25–34)

Amongst those who had not engaged in counselling, a few commented that they thought they would find the experience stigmatizing, or were concerned that attending counselling would itself cause stigma:

I'd get ostracised at work. (52, F, 25–34)It makes you feel like you have a worse problem than you do. (41, M, 18–24)

A few participants who had received counselling were not returning, as they had felt judged and criticized by their counsellor, reflecting what has been termed 'professional stigma' (Angermeyer, Matschinger, & Schomerus, 2013; Griffiths, 2011). One contended:

The counsellor is just waiting for me to fall out of line, and then it'll be no stopping her. (8, F, 55–64)

Online and telephone support

About half the participants had sought help via online or telephone services. There was no indication that participants felt judged or stigmatized by these services, likely due to their anonymity. Previous research (Cooper, 2001, 2004) has found that using anonymous forms of help allows people to avoid some forms of stigma by being able to withhold personal information and have greater control over disclosure. Indeed, 70% of participants using online gambling help in Cooper's (2001) study had previously avoided using face-to-face gambling services due to fear of stigma.

Concluding comments

This study explored how people with gambling problems experience and cope with perceived and self-stigma. Highly evident was the overwhelming perception that problem gambling attracts high levels of public stigma, and that the public views problem gambling as being caused by personal failings. These findings are consistent with stigma theories (Corrigan et al., 2003; Jones et al., 1984; Weiner, 1986) and with the limited previous research into problem gambling stigma (Carroll et al., 2013; Dhillon et al., 2011; Feldman & Crandall, 2007; Horch & Hodgins, 2008). Participants' perceptions of the public stigmatization of problem gambling also reflected all elements theorized as comprising the process of stigma creation (Link et al., 2004). This suggests that the formation of problem gambling stigma probably occurs through similar mechanisms to those for other mental disorders. Many

participants appeared to have internalized perceived stigma as self-stigma, with deleterious effects reported on self-esteem, self-efficacy, perceived social worth, and mental and physical health. Deep shame was a near universal emotion amongst participants with self-stigmatizing beliefs, prompting secrecy as the main coping mechanism (Link et al., 2004) to preserve a (problem-free) social and subjective identity (Goffman, 1963). The findings confirmed that perceived and self-stigma are major barriers to seeking help for problem gambling (Gainsbury et al., 2014; Hodgins & el-Guebaly, 2000; Rockloff & Schofield, 2004; Tavares et al., 2002).

The importance of addressing stigma towards many mental illnesses has been recognized internationally. The World Health Organization (2001) has highlighted the need to combat stigma related to mental illness and promote action against such stigma. Public education and awareness campaigns may reduce stigma and discrimination, increase use of treatment services, and close the gap in the perception of mental and physical health as two distinct issues. However, research on educational campaigns suggests that these tend to reach those who already agree with the message (Rüsch et al., 2005). Importantly, some campaigns about problem gambling may actually increase stigma, by increasing the separation between 'us' and 'them', such as by describing people with gambling problems as neglecting their families, unable to pay their bills, and irresponsible. Therefore, care is needed to create an appropriate message, which is difficult given the diversity of communities targeted.

Involving families and consumers in the planning and development of policies, programmes and services may also help provide a powerful, vocal and active force for change. Stigma may be reduced by increasing the contact of communities with people with gambling problems, as this contact may decrease stereotyping (Rüsch et al., 2005). Including contact with consumers has been found to increase the effectiveness of educational interventions (Pinfold et al., 2003; Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003). By replacing stereotypes with more positive images, public stigma towards people with gambling problems may be reduced.

Making treatment services and interventions available in a more anonymous, private way may reduce the extent that stigma is a barrier to these. Broader provision of online treatment options may be highly useful to encourage help-seeking for gambling problems as these enable anonymity (Gainsbury & Blaszczynski, 2011; Rodda & Lubman, 2014). Although this may not reduce stigma, it may encourage help-seeking, which can lead to reduced problems and addressing self-stigma. Efforts may also be needed at an institutional level; for example, by educating health professionals about stigma, how to reduce stigma, and the importance of screening for gambling problems. Similarly, there is also room for intervention with service providers, who are not immune to stigmatizing their own clients (Gray, 2002). One study (Hayes et al., 2004) has found preliminary evidence for an intervention based on Acceptance and Commitment Training that may successfully reduce stigmatizing attitudes and behaviour in counsellors.

A precondition for effective stigma-reduction interventions is to arrive at a valid model for the stigma of the condition being examined (Schomerus et al., 2011). It is hoped that this initial research into stigma-related experiences will prompt further research to better understand problem gambling stigma and efforts to reduce its deleterious effects. Stigma is a complex phenomenon and much more research is needed, including on the stigma on families of people with gambling problems and on structural discrimination, especially within the health care system. Knowledge is also scant about the effects of stigma within co-morbid conditions, which is important, given that gambling problems are highly co-morbid with other mental health issues (Black & Moyer, 2014; Petry, Stinson, & Grant,

2005). Research is also needed into how stigma is affected by having multiple marginalized statuses in addition to problem gambling, such as other addictions, mental health disorders and homelessness. Attention to multiple disadvantaged social statuses is important in designing effective interventions to combat stigma and to find the root cause of health disparities (Stuber, Mayer, & Link, 2008). Having multiple marginalized statuses has been found to have differing effects on stigma (Deacon, 2006; Goudge, Ngoma, Manderson, & Schneider, 2009; Meyer, Schwartz, & Frost, 2008), but this has not been investigated for problem gambling. Additionally, the role of gender in problem gambling stigma requires dedicated studies, especially considering that females appear to be less stigmatized than males for having a mental health problem (Farina, 1981), but more stigmatized for alcohol or drug abuse (Robbins, 1989). Hing et al. (2014) have speculated that women are more likely to be and feel more stigmatized for problem gambling due to a perceived failure to live up to expected gender roles, which can lead to intense shame and guilt. However, men may also feel comparable levels of shame and guilt if they fail in performing their traditional gender role of breadwinner (Simon, 1995).

Although awareness of the impact of stigma is increasing in some jurisdictions, further research is needed to identify and develop strategies to best reduce stigmatizing attitudes and behaviours, and to increase the strategies for people with gambling problems to cope with stigma until public stigma has substantially diminished.

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Conflicts of interest

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