

**How does the stigma of problem gambling influence help-seeking, treatment and recovery? A view from the counselling sector**

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**Abstract**

Problem gambling attracts considerable public stigma and can cause significant self-stigma. However, little research has investigated the role of stigma during treatment-assisted recovery from problem gambling. This study aimed to examine gambling counsellors' perspectives on whether and how the stigma associated with problem gambling influences problem acknowledgement, help-seeking, treatment and recovery. In-depth interviews with nine gambling counsellors from Victoria Australia were analysed to extract shared meanings of experiences using interpretative phenomenological analysis. Counsellors indicated that the burden of problem gambling is

typically increased by the addition of stigma and its impacts. This stigma is created and maintained by a lack of public understanding about problem gambling and its causes, and internalisation of self-stigmatising beliefs, leading to delayed help-seeking, anxiety about attending treatment, concerns about counsellor attitudes, and fear of relapse. Counsellors maintained that, before effective gambling treatment could occur, they needed to help clients overcome their self-stigmatising beliefs to establish confidence and trust in the counsellor, restore self-esteem, enhance stigma coping skills, and foster a belief that recovery is possible. Harnessing support from significant others and preparing clients for relapse were also important inclusions to lower stigma. Addressing stigma early in treatment can help to improve treatment adherence and recovery.

## **Introduction**

Problem gambling appears to attract considerable public stigma (Hing, Holdsworth, Tiyce & Breen, 2014; Hing, Russell, Gainsbury & Nuske, 2015a). Having a gambling problem is commonly perceived as shameful and largely an individual's own fault, with blame mainly attributed to a person's own failings, including their bad character, having an addictive personality, or a lack of self-control (Carroll, Rodgers, Davidson & Sims, 2013; Horch & Hodgins, 2008). 'Problem gamblers' have been stereotyped as compulsive, impulsive, desperate, irresponsible, risk-taking, depressed, greedy, irrational, antisocial, and aggressive (Horch & Hodgins, 2013). Negative stereotypes such as these typically lead to the formation of negative societal attitudes towards those affected

(Corrigan, 2004; Corrigan & Shapiro, 2010) and their devaluation and disqualification from full social acceptance (Goffman, 1963; Crocker, Major & Steele, 1998).

This public stigma may lead to self-stigma, where individuals with a stigmatised condition internalise and apply perceived societal conceptions to themselves (Corrigan, 2004; Watson, Corrigan, Larson & Sells, 2007). People with gambling problems have been found to adopt self-stigmatising beliefs, which manifest as feelings of shame, embarrassment, guilt, stupidity, weakness and low self-esteem (Carroll et al., 2013; Hing, Nuske, Gainsbury & Russell, 2015b). Whether stigma is directly experienced or only perceived, these self-stigmatising beliefs diminish self-esteem, self-efficacy and self-perceptions of social worth (Corrigan, 2004; Watson, Corrigan, Larson & Sells, 2007).

Self-stigma most noticeably manifests as reluctance to seek professional treatment. Having a spoiled social identity can adversely impact on subjective identity, prompting concerns about whether and how much to disclose a stigmatised condition to others (Goffman, 1963). People's desire to manage their identity by hiding shameful problems or characteristics, to protect themselves from being shunned by society and significant others, explains why many individuals keep a gambling problem hidden and avoid seeking formal help (Carroll et al., 2013; Hing et al., 2015b). An international review (Suurvali, Cordingley, Hodgins & Cunningham, 2009) found that the stigma associated with problem gambling is a major barrier to help-seeking and uptake of professional

treatment. Additionally, once people with gambling problems finally seek formal treatment, they are likely to carry substantial self-stigmatising beliefs which can impede their treatment and recovery (Carroll et al., 2013; Hing et al., 2015b). Understanding the role that stigma plays within treatment is therefore essential to enable counsellors to incorporate strategies to overcome these issues and enhance successful client outcomes.<sup>1</sup>

### **Stigma and problem acknowledgement, help-seeking, treatment and recovery**

Help-seeking for problem gambling is a multi-step process and self-stigma can hinder each step involved, from problem acknowledgement through to treatment completion (Carroll et al., 2013). People may be reluctant to acknowledge a gambling problem for fear of self-identifying as ‘a problem gambler’, as this is likely to contradict their desired self-concept and erode self-dignity; therefore, assertion of a contrary identity to ‘problem gambler’, even to the self, is a strategy used to retain self-worth (Hing et al., 2014). As such, denial and concealing actions amongst those with a gambling problem appears common (Suurvali et al., 2009). Significant others are often shocked to learn of a loved one’s gambling problem, not least because the problem had typically been concealed for so long through considerable efforts (Holdsworth, Nuske, Tiyce & Hing, 2013; Patford, 2008, 2009).

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<sup>1</sup> ‘Clients’ is the term most frequently used in Australia for people attending counselling. Elsewhere they may be referred to as ‘patients’.

Stigma also presents a barrier to finding out about available help, and hinders building the confidence to actually seek help (Carroll et al., 2013). Using qualitative (Carroll et al., 2013; McMillen, Marshall, Murphy, Lorenzen & Waugh, 2004), quantitative (Hodgins & el-Guebaly, 2000; Rockloff & Schofield, 2004; Tavares, Martins, Zilberman & el-Guebaly, 2002), and mixed-methods approaches (Hing, Nuske & Gainsbury, 2012), several studies have identified stigma-related concerns, including shame, secrecy and embarrassment, as one of the major barriers to treatment-seeking for problem gambling. However, these studies did not investigate how treatment providers incorporate these concerns into treatment to assist clients to cope with self-stigma, with possible relapses, and with other stigma-related barriers to recovery. Strong resistance to disclosure means that most individuals try to resolve the gambling problem alone initially by using self-help measures (Hing et al., 2012). It is only at crisis point that people may reach out for help, as a last resort; thus help-seeking rates remain low (Cunningham, 2005; Hing et al., 2012; Delfabbro, 2012).

Mental health stigma is one of the most commonly reported barriers to initiating help-seeking (Clement et al., 2015) and is also a predictor of treatment discontinuation (Sirey et al., 2001), as attending therapy carries substantial stigma in itself (Corrigan, 2004). To engage in treatment is to admit to needing help, which may be perceived by self and others as a weakness and acknowledgement of failure; indeed, the accompanying feelings of incompetence and inferiority may be worse than enduring the mental health problem

(Vogel, Wade & Haake, 2006). Corrigan (2004) explains that many people fail to participate, or participate fully, in mental health treatment to evade the damaging label of mental illness, which lowers self-esteem through self-stigma and undermines social opportunities through the stereotyping, prejudices and discrimination accompanying public stigma. Several researchers have discussed the pathologising of problem gambling as deficit or disease (Castellani, 2000; Cosgrave, 2008; Reith, 2007; Reith & Dobbie, 2012; Rosecrance, 1985), heightening the subsequent stigma of being classified and labelled as having an illness which needs to be treated and cured. Corrigan (2004) contends that the desire to avoid a stigmatising label (such as 'problem gambler') is the most significant way in which stigma impedes treatment.

Given the considerable self-stigma that problem gambling clients are likely to bring to treatment, reduction of self-stigma appears to be an important component of therapy. Reith and Dobbie (2012) found that shifting concepts of self-identity and reshaping of self were integral to the process of recovery from problem gambling, reflecting transition from a self-stigmatised identity to an unspoiled one. Self-stigma reduction strategies for mental illness have attempted to alter clients' self-stigmatising beliefs or, more commonly, endeavoured to enhance skills for coping with self-stigma through improving self-esteem, empowerment and help-seeking behavior (Mittal, Sullivan, Chekuri, Allee & Corrigan, 2012). Thus, addressing client embarrassment, shame and fears about stigma during early stages of treatment may be an important component of problem gambling

therapy (Dunn, Delfabbro & Harvey, 2011), although this topic has attracted little research.

Minimal research has also investigated how clients and counsellors navigate and address stigma during treatment. Anderson (2014) points out that effective treatment assumes that clients engage in open and frank discussions with therapists, and that therapists convey accepting, non-judgmental, safe and non-stigmatising attitudes. Clients in his qualitative study variously adopted, challenged or resisted certain stereotypes and labels of their stigmatised status that were applied by counsellors and, when this occurred, sometimes limited disclosure to their therapist or terminated treatment (Anderson, 2014).

Stigmatising attitudes of mental health practitioners can influence treatment outcomes (Angermeyer, Matschinger & Schomerus, 2013; Flanagan, Miller & Davidson, 2009; Griffiths, 2011; Schulze, 2007; Wahl, 1999; Wahl & Aroesty-Cohen, 2010), so practitioners need to be sensitive to stigmatised populations in the language and approaches used during therapy.

A further consideration in treatment-assisted recovery is relapse. Relapse is a common experience amongst recovering problem gamblers (Smith et al., 2013), and is typically accompanied by feelings of failure, shame, humiliation and embarrassment (Petry, 2005). Clients may terminate treatment rather than 'failing' their therapy and therapist (Dunn et al., 2011). Relapse prevention strategies appear to be common, beneficial inclusions in

problem gambling treatment (George & Murali, 2005; Oakes et al., 2012), yet efforts to destigmatise relapse may not be so commonplace. Dunn et al. (2011, p. 25) advocate for early, open discussions between practitioners and clients ‘about the possibility, but not the definite fatality, of relapse during therapy’, but little is known about adoption of this practice.

The preceding literature review has identified numerous ways in which stigma may impact on the help-seeking and recovery process for problem gambling, but little is known about how gambling treatment providers incorporate these issues into their counselling approaches. The current study aimed to understand gambling counsellors’ perspectives on how the stigma of problem gambling influences problem acknowledgement, help-seeking, treatment and recovery. Related research questions were: 1) how and why might stigma be a barrier to problem gambling acknowledgement and seeking professional treatment?; 2) how does stigma influence treatment and recovery?; 3) how does relapse influence stigma and treatment?; and 4) how does stigma influence the role of significant others in the gambler’s help-seeking, treatment and recovery? Addressing these questions will contribute to a deeper understanding of problem gambling stigma, inform efforts to improve help-seeking, professional treatment and recovery from problem gambling, and provide some foundational knowledge to assist future research endeavours.

## Methods

Approval for this study was gained from XXX [withheld for anonymity during review] Human Research Ethics Committee. The research design incorporated a qualitative approach which sought to interpret, understand and explain the meanings of participants' experiences (Neuman, 2007; Wolcott, 1994). As a qualitative approach considered suitable for researching under-represented or marginalised groups (Creswell, 2007), phenomenology was employed to generate rich and thick descriptions through in-depth interviews (Geertz, 1983). Phenomenology is the study of shared meanings of experiences of a phenomenon for a range of people (Creswell, 2007). It involves understanding the meaningful concrete relations implicit in original descriptions of experiencing the phenomenon (Moustakas, 1994). The researcher gathers data as lengthy interviews describing the shared participants' experiences and then reduces these data to a central meaning, or 'essence' of the experience. Highly structured interview questions are not used extensively because the purpose is to explore participants' views of what is important rather than to examine what the researchers believe is important (Smith, Jarman & Osborn, 1999). A rich study keeps asking questions like when, why, how, and under what circumstances the phenomenon occurs (Rubin & Rubin, 1995), so that a detailed understanding can be gained. Gambling treatment providers are a valuable source of insights, given they are exposed to the self-stigma that clients bring to therapy, ideally provide treatment that is sensitive and appropriate to clients' self-stigmatising

beliefs, and support recovery by empowering clients to deal with both their gambling problem and the associated stigma

### *Recruitment of participants*

To recruit interviewees, we first emailed all 18 Gambler's Help agencies in the Australian state of Victoria to request for one or more of their counsellors to participate in the study. Gambler's Help agencies are a network of organisations across Victoria funded to deliver treatment and support for people with gambling problems and their families, including free and confidential counselling, financial counselling and peer support programs. Many of these agencies were reticent to participate without approval from the government agency overseeing these services, the Victorian Responsible Gambling Foundation. At our request, the Foundation emailed all counselling agencies to encourage and approve their participation. After telephoning each agency, we gained permission to interview nine counsellors. These comprised one counsellor from each of eight of the 18 agencies and one from the peer support program. Gambling counsellors provide free, confidential information, advice and counselling to anyone affected by gambling in Victoria, while the peer support program provides a confidential, anonymous, telephone program staffed by volunteers who have themselves experienced problems with gambling or worked through the impact of someone else's gambling.

### *Participants*

Of the nine interviewees, seven were female and two were male. They had been working in gambling help services from two to 15 years. All were gambling counsellors, except for one male participant whose primary role was as a peer support worker. Most worked in services that were not culturally-specific, although all participants worked with clients from a wide range of ethnic backgrounds reflective of Australia's multicultural society.

### *Procedure*

After gaining individual written consent, telephone interviews, each lasting approximately one hour, were conducted by two authors with experience in interviewing problem gambling counsellors. The semi-structured interview guide (Appendix 1) was sent to counsellors in advance, along with a participant information sheet, to encourage considered responses grounded in their professional experiences with clients.

Counsellors were asked to describe their understanding of stigma. Focusing on client experiences, they were then asked to detail the self-stigmatising beliefs that clients brought to treatment, and to explain whether and how this affected clients' acknowledgement of their gambling problem, decision to seek treatment, support from significant others, recovery and relapse. Counsellors were also asked to describe how and why they incorporated considerations for clients' self-stigma into their treatment.

### *Analysis*

The interviews were recorded and transcribed verbatim by a professional service.

Transcripts were analysed using a combination of interpretative phenomenological analysis (IPA; Larkin & Thompson, 2012) and thematic analysis (Braun & Clarke, 2006). IPA explored in detail how participants made sense of their professional experiences of problem gambling stigma, and the perceptions and interpretations they placed on these experiences (Smith et al., 1999). Themes and sub-themes were identified manually from participants' accounts, and connections made to group them in a meaningful way.

Four major themes were identified a priori, based on the four research questions, in order to ensure these were addressed in the analysis. One author then coded the data and inductively extracted sub-themes within each major theme. These initial themes and sub-themes were then reviewed by the two interviewers to ensure that, in total, they captured the essence of the interviews. Some changes were made to the names of sub-themes as a result of this process. To ensure trustworthiness of the analysis (Lincoln & Guba, 1985), another author then reanalysed the data, by independently extracting sub-themes from within the four major themes through a coding process which also tallied the number of times each sub-theme was mentioned. As found by Armstrong, Gosling, Weinman and Marteau (1997) who formally assessed the degree of inter-rater reliability that might be expected in qualitative analysis, the two analyses showed close agreement on the basic themes and sub-themes, but each analyst named the sub-themes and grouped them into the major themes somewhat differently. Following discussion, the two analysts reached

100% resolution on the nomenclature and assignment of the sub-themes within major themes, as shown in Table 1. Additionally, based on discussion and comparison of all results, one sub-theme ('fear of negative judgments by others') was expanded to include the concept of 'shame', to fully reflect the underlying phenomenon. Calculating a formal inter-rater reliability score, which is appropriate for content analyses that seek to quantify qualitative data, was considered unsuited for IPA and is little used in phenomenological studies (Krippendorff, 2004; Marques & McCall, 2005). Instead, we agree with Barbour (2001) that the value of multiple coding does not lie in the degree of concordance achieved by analysts, but in the insights, refinements and rigour that discussions between multiple coders bring to ensure that competing interpretations are resolved.

Emphasis was given to anchoring the participants' accounts in the write-up, thus providing meaningful insights (Smith et al., 1999). To guarantee confidentiality and anonymity, each counsellor was assigned a code: M or F (gender), and a participant number beginning at 01, as attached to quotations below.

## **Results**

Table 1 summarises the themes and sub-themes that emerged during the analysis. As the recurrence of emerging themes can indicate their relative importance (Collingridge, 2013), the number of times each theme and sub-theme was mentioned by the counsellors was counted (Table 1). The four main themes were purposefully aligned with the four

key aspects of the research aim: 1) stigma as an initial barrier to problem gambling acknowledgement and professional treatment (90 mentions); 2) stigma, treatment and recovery (19 mentions); 3) stigma and relapse (21 mentions); and 4) stigma and the role of significant others in the gambler's help-seeking, treatment and recovery (32 mentions). Every counsellor except one expressed these four main themes. The exception, mentioned just three themes.

*Insert Table 1 about here*

***Theme 1: Stigma as an initial barrier to problem gambling acknowledgement and professional treatment***

All counsellors perceived both public stigma and self-stigma to be associated with problem gambling. They interpreted public stigma as negative attitudes and judgments held by the general public towards people with gambling problems, underpinned by a general lack of understanding about impaired control over gambling and gambling-related problems. Fear of being labelled a failure or being perceived as an unacceptable person based on negative gambler stereotypes often led to embarrassment, loneliness and declining self-esteem amongst clients, reflecting their self-stigmatising beliefs. Concerns about misunderstandings, damaging gossip, shame and '*other people judging them*' (F\_08) were barriers preventing many gamblers from self-acknowledging their problem for quite some time. For example, one counsellor explained:

*... it takes quite some time for some people or most people to realise when something has sneaked up on you, which most addictions sneak up on people. One moment it is fine and they're able to cope ... and ... there's that denial process that people go through ... 'I'm a person who can manage and control my life and people see me as that person. And if I ever admit to myself that this is as out of hand ... I might not be even to look at myself in the mirror' (F\_04).*

Self-stigma amongst clients was reported as feelings of shame, humiliation and internal anger based on failure to maintain self-control over gambling. This usually produced secrecy, lying and concealment of gambling problems and relapse episodes, all in the hope of solving the issue themselves perhaps by winning their way out of their escalating problems. Barriers to seeking help were created by their embarrassment and inner fears of weakness and failure, and of facing humiliation if they disclosed their problem to others. One counsellor explained these barriers as follows:

*It is stigma that prevents them from approaching either their own family members for support or ... professional services. It takes them quite a long time ... before they overcome the barrier... shame ... prevents them from ... admitting to themselves ... they need to seek help ... (F\_09).*

Generally, after living through a period of denial, seven of the nine counsellors related that clients usually experienced '*high crisis*' (F\_01), such as bankruptcy, harassment from loan sharks, marriage breakdown, or a suicide attempt, which was a significant milestone in prompting help seeking. Before that crisis, '*the stigma sort of stands in the way*' (M\_07). While a significant crisis typically prompted clients to consider seeking help, many were fearful of the consequences of disclosure, holding back '*because of the fear of the unknown*' (M\_06). The majority of counsellors commented that clients were fearful of being seen as weak and reckless, that they may not be supported or succeed, and that they may not be able to trust the professionals in whom they confide. A lack of control over their gambling activities usually lowered self-esteem and deepened shame associated with disclosure and with seeking treatment, with many clients being '*secretive about attending counselling*' (F\_01). Two counsellors explained this reticence as follows, with the first emphasising reticence to disclose to others, and the second emphasising reticence to disclose to the counsellors themselves:

*They may have been seeing me for a couple of months and they still haven't talked to anybody else, because there's that feeling that if people really knew how bad it was, they wouldn't accept them (F\_04).*

*Once they seek help, it's a question of how much are you going to be open about in the session? Often times, stigma interferes to such an extent that counsellors*

*don't get the full picture 'til about the sixth or seventh session where there are a lot of these other things coming out ... which ideally, if they were motivated to seek help, they would've revealed in the first two sessions (F\_09).*

Anonymously seeking information online and/or calling a helpline were often initial approaches because the barrier of stigma discourages asking for personal help for as long as possible (F\_08), making it very hard for clients to *'come through their door'* (F\_02). Nevertheless, the pressing need to lower the stress caused by lack of money, debt, arguments, legal reasons and more, motivated clients to overcome these barriers to seek treatment. Additionally, the physical, emotional, social or psychological needs of their partners, families or friends were said to motivate client help-seeking. Although significant others might be supportive or threatening, they were often an important force behind clients overcoming the barrier of stigma to seek help, according to eight counsellors.

### ***Theme 2: Stigma, treatment and recovery***

A strong desire for anonymity and confidentiality to avoid public stigma typically delays approaching professional services for problem gambling, and six counsellors emphasised the importance of gaining clients' trust when they finally did. One explained:

*... they are extremely cautious when they approach you ...it's almost like I'm being tested as a counsellor to preserve the privacy or confidentiality ... And it's a make or break situation in those cases because, if you aren't able to explain it properly, you end up losing the client (F\_09).*

One of their first goals, five counsellors reported, was to work with clients to reduce self-stigma, allowing understanding, forgiveness, healing and recovery to follow. Most clients go through stages of change in addressing their gambling problem. Some clients realise that *'the visions, the hopes, the values that they have for themselves ... gambling doesn't fit into any of those'* (F\_02). Counsellors maintained that treatment needs to first address underlying shame and self-stigma before acceptance, trust and a belief in recovery are possible. Thus, counsellors reported finding ways to explore self-stigma and its uncomfortable accompanying emotions. By asking clients to tell their story, why they hold self-stigmatising beliefs, and what it means for them, then trying to change their thinking about the disgrace and shame they feel, clients may begin to realise that they are not hopeless or worthless. Clients need to feel valued and worthy for healing to begin. As confidence is gradually re-established, clients are encouraged to remember the positive features of their lives and their former identity. One counsellor explained:

*... it's a broken identity... the gambler, to rebuild the identity, to rebuild the trust, to prove to the partner and to the family that he's better, it's a process... to get in*

*touch with the personal needs and goals and what he wants to achieve and to understand what's happened ... [in] that counselling' (F\_08).*

Counsellors then used a range of treatment options that focused on altering thinking patterns and behaviour, including cognitive behaviour therapy, exposure and narrative therapies, and motivational interviewing. Motivational interviewing checks the insights that clients have in acknowledging their problem and their readiness for change.

Counselling helps to empower clients to understand and alter their shameful feelings.

Counsellors explained that empowerment, self-esteem and trust need to be rebuilt before changes to the gambling can occur. With appropriate exploration led by the counsellor, clients may recognise when they are ready for change by learning to think and behave differently.

### ***Theme 3: Stigma and relapse***

Eight of the nine counsellors viewed relapse as a typical part of recovering from problem gambling. Because clients have overcome high barriers to attend treatment, one reason for them to stop is the shame they may feel if they think they cannot continue. This may exacerbate feelings of hopelessness, guilt and low self-esteem for failing their counsellors, especially for '*clients that have developed quite a strong relationship with you*' (F\_03). Counsellors therefore worked hard to educate clients early in their treatment about the normality of relapse. They explain the change cycle and identify relapses in that

cycle, and discuss causes and behaviours, a return to counselling and what learning might result from each relapse episode. For instance, one counsellor took the following approach to help clients use their relapse experience to develop processes and strategies to assist them in managing future gambling triggers and urges:

*I look at the normalising ... the change cycle ... the relapses ... when somebody comes back in ... [I ask] what exactly happened? And learning from that ... that's the opportunity ... to manage this ... situation differently ... in the future ... going deeper into getting control (F\_07).*

From the counsellors' accounts, three groups emerged with different responses to relapse. One group comprised clients who relapsed while in treatment but returned to counselling quickly. The education process and counsellors' acceptance of relapse as normal were critical elements in preparing these clients for relapse, as seen in this comment: *if I have been able to do my job well ... they will ... know that there won't be any condemnation ... any judging from me (F\_04).*

A second group were thought to be too ashamed to return for counselling after relapse. From the counsellors' reports, the self-stigma of this group increased as they blamed themselves for failing. They felt they had betrayed their counsellor and family, and with increasing remorse their counselling often stalled. As indicated here, when the length of

time between counselling sessions grew: *[after] six months, there's more shame* (F\_03). Clients who do not return for counselling may give up and accept their self-stigmatising beliefs of being a failure, rationalising this as expressed below:

*'Oh. I've tried and it didn't work. It's almost like destiny has told me that this is how I am going to be. This is my life ... It's my fault'. They find it very hard to pick themselves up again. They burden themselves with guilt. Felt stigma becomes even further embedded into their being* (M\_06).

Another group, mostly men, after unsuccessfully trying to help themselves, were inclined to use counselling to seek help for their immediate problems, which were often financial. Afraid of publicity, they sought anonymous, quick and confidential solutions. They were often less open to uncovering the source of their gambling problem. One counsellor suggested this was because: *when they keep ... gambling as a secret ... they have control over that stigma* (F\_08). Another counsellor saw negative community attitudes and fear of publicity affecting gamblers in this group (F\_02). With time, these clients were likely to return to counselling because the same problems re-emerged with gambling relapse. Public stigma, and to a lesser extent self-stigma, appeared to affect the views and behaviour of this client group. Attitudes of counsellors and the strategies they tailored for clients were very important in

managing relapse to encourage eventual control and recovery from gambling problems.

***Theme 4: Stigma and the role of significant others in the gambler's help-seeking, treatment and recovery***

Counsellors were asked how the supportive or stigmatising attitudes and behaviours of significant others affected clients' propensity to seek, attend and benefit from treatment. Seven counsellors indicated that some families did not support problem gambling members, some did, while others gradually changed their attitudes and support over time. Not knowing how significant others would react, clients were likely to hide their problem for as long as possible. Generally, admissions were forced by a financial crisis. Ideally however, counsellors try to convince clients to disclose their problem to significant others to build a support base using familial and other close resources. Counsellors often seek co-operation in working towards gambling recovery.

However, some significant others cannot accept problem gambling members, according to three counsellors. This rejection may be based on misunderstanding and then abandonment where: *'some members of the family ... will say, 'Come on, stop that' ... then [when they don't stop] they reject them (F\_05)*. For others, lack of trust is the main issue, often based on broken promises, lies, disputes, unpaid loans and theft of family valuables. The family expects the cycle of gambling, losses and relapse to continue, have

no hopes about recovery and avoid the gambler and their problems. These abandoned clients can become isolated and afraid of the future, feeding into self-stigma as significant others increasingly shun them.

In contrast, several counsellors described families who became very supportive once they knew about the issue. It was often a great relief for clients to share their problems with significant others who then typically provided moral support, avoided social activities in gambling venues, encouraged engagement with gambling help, and assisted with budgeting. Most gamblers reported to counsellors that this help and encouragement were major factors in their recovery. A counsellor described her encounter with one couple:

*... [he had been to] counselling for a few weeks and then he brought his wife ... he came with the sunglasses because he was so ashamed. ... couldn't even bare his face in the room ... the sunglasses ...the symbol of his shame ... but he kept coming and his wife was supportive and understood that. (F\_08).*

Some mixed reactions of significant others were also related. Partners who knew about the gambling problem were sometimes hesitant to share this information with extended family and friends for fear of negative consequences and stigma, because: *[when] your family name is ... held in high regard ... if you do something ... that is bad it ... comes back upon the family name (M\_06)*. Several partners were reported as being very worried

that their gambling spouse would be labelled as weak or wicked. One counsellor described: *a woman [who] has not let her family know ... she thinks that they think that he is a bad person ... she loves him* (F\_07). Some felt that they might be seen as having failed their spouse and thus be equally to blame. Disclosing the gambling problem would reveal unknown aspects of their lives; aspects not recognised by significant others. Thus, some were unwilling to disclose their partner's gambling problem to extended family as the ripple effect of stigma can include spouses.

Shifts in how significant others responded to problem gambling family members were obvious to the majority of counsellors. When the cycle of problem gambling and relapse was continually repeated, some significant others became weary of the physical, emotional, relationship and financial demands on them. Doubt and distrust following relapses often led to deteriorating relationships and reduced support, as this comment indicates: *... if they really cared about me ... really wanted to make a change ... really meant business, they would just stop* (F\_04). Recovery seemed unachievable for some as time passed. Problem gambling and subsequent stigma often doubled a gambler's self-stigmatising shame: shame about having a gambling problem and then shame of being rejected by family and friends.

## **Discussion**

The study's findings indicate that public stigma, underpinned by misunderstandings that self-control or abstinence are easily applied to resolve a gambling problem, is internalised by many clients as damaging self-stigma. This then becomes a powerful barrier to problem acknowledgement and to seeking support and treatment, as preservation of an unspoiled identity motivates denial and secrecy (Carroll et al., 2013; Goffman, 1963; Hing et al., 2015b). Better public understanding could therefore encourage more awareness about the nature of problem gambling as a behavioural addiction rather than a failure of character. Recent research indicates that 'problem gamblers' are negatively stereotyped as irrational and irresponsible (Hing et al., 2015a; Horch & Hodgins, 2013), and considered at fault for their problem, with blame targeted towards the person's own weakness and lack of self-control (Carroll et al., 2013; Hing et al., 2015b; Horch & Hodgins, 2008). Dispelling these assumptions should lead to less public and self-stigma and potentially enhance help-seeking rates for problem gambling from their currently low rate (Cunningham, 2005; Hing et al., 2012; Delfabbro, 2012).

Help-seeking, most counsellors agreed, was usually precipitated by a catastrophic event, forcing clients to face the associated stigma and its consequences. After trying self-help, many clients sought anonymity in their treatment, choosing telephone or online assistance before seeking face-to-face help, in a staged process of disclosure (Cooper, 2001). This is consistent with research showing that stigma appears to accumulate, becoming a barrier for both problem gambling acknowledgement and help-seeking

(Gainsbury et al., 2014; Hing et al., 2012; Hodgins & el-Guebaly, 2000; Pulford et al., 2009; Rockloff & Schofield, 2004; Tavares et al., 2002). Again better public understanding about gambling problems and promoting the benefits of professional treatment may reduce the associated stigma and encourage those affected to seek help early.

Most counsellors agreed that dealing with self-stigma was one of their first tasks in treatment, as promoted by Dunn et al. (2011). This requires openness, understanding and empathy (Anderson, 2014), so establishing confidence and trust were perceived as crucial first steps before gambling treatment could occur. Counsellors reported trying to create safe settings, teach stigma-coping mechanisms, alter clients' self-stigmatising beliefs, and restore clients' self-esteem and self-efficacy. However, it may take many sessions before clients can sufficiently overcome their deep shame to be honest and open with counsellors. Therapists therefore need to maintain accepting, non-judgmental and non-stigmatising attitudes so that problem gambling clients adhere to and benefit from treatment (Anderson, 2014).

Counsellors tried to harness any client support from significant others. However, significant others held a broad range of attitudes that helped stigma reduction for some clients, but further stigmatised others through rejection and social distancing (Link, Yang, Phelan & Collins, 2004). As advocated by others (Hing et al., 2012), research is needed

to identify how loved ones can best assist the resolution of a gambling problem while also protecting themselves from its impacts and the stigma that often extends to them (Corrigan & Miller, 2004; Goffman, 1963).

The counsellors generally considered that relapse compounded stigma as negative stereotypes, self-imposed stigma and humiliation tended to rise again for clients. Therefore, some clients delayed or avoided returning to treatment, due to feelings of failure, humiliation and shame (Dunn et al., 2011; Petry, 2005). Reflecting the common occurrence of relapse (Smith et al., 2013), all counsellors agreed that discussion about relapse was an early priority in treatment in order to normalise it, minimise further self-stigma and optimise treatment adherence, and that learning from relapse episodes could improve how clients deal with future gambling triggers and urges.

This interview sample of gambling counsellors was not intended to be representative of all gambling counsellors and was recruited on a convenience basis. However, in-depth qualitative research aims to provide detailed insights and capture the range of experiences, rather than provide representative or quantified data. Future research might include larger samples, different geographic locations and cross-cultural populations of counsellors. Additional research is especially needed to ascertain how stigma-related barriers to help-seeking, treatment adherence and treatment efficacy might be reduced.

## **Conclusion**

This research with counsellors indicates that the burden of problem gambling is typically increased by the addition of stigma and its impacts. This stigma is created and maintained by a lack of public understanding about problem gambling and its causes, and internalisation of self-stigmatising beliefs, leading to delayed help-seeking, anxiety about attending treatment, concerns about counsellor attitudes, and a fear of relapse instead of quick recovery.

Achieving a better understanding of the nature of problem gambling through public health awareness and community education campaigns, similar to those organised for mental illnesses such as depression, may lead to more tolerant attitudes and eventually to some reduction in public stigma. If people with gambling problems believe that problem disclosure will not be accompanied by stigmatising attitudes that lower self-esteem and their resilience, then problem acknowledgement and help-seeking rates might increase. The provision of counselling by professionals with non-judgmental attitudes who are able to explain stigma and help clients to address its impacts may assist with recovery. Similarly, discussions about relapse and its normalisation as part of the recovery process, may do the same.

## **Appendix 1: Interview questions for gambling counsellors**

The first few questions relate to what you think stigma is and what you can tell me about how your clients have experienced stigma in relation to their problem gambling. This is followed by a few questions about your own views as a professional counsellor.

**A. What you think stigma is.**

1. Firstly, are you please able to describe what you think stigma is.

**B. The perceptions and experiences of your clients: *Prompt – ask for concrete examples throughout***

1. How do your clients feel they are viewed by others because of their gambling?  
*Prompt – do they feel labeled or stereotyped or frowned upon?*
2. Have clients talked about feeling stigmatised or ashamed because of their gambling? *Prompt – past and present experiences.*
3. How have client experiences of any stigma or shame affected their acknowledgement of having a gambling problem?
4. How have client experiences of any stigma or shame affected their decision to seek treatment? *Prompt – in what ways, e.g., delayed, a barrier? Do they feel shame or stigma in seeking treatment?*
5. How have client experiences of any stigma or shame affected their decision (or not) to self-exclude *Prompt – in what way has it affected this decision?*
6. How have client experiences of any stigma or shame affected their decision (or not) to engage with peer support groups, such as GA? *Prompt –How? Why?*

7. Do clients report feeling stigmatised by family and friends? How does this affect whether they reach out for or get offered support from family and friends? And do family and friends themselves feel stigma or shame because of their loved one's gambling?
8. How have client experiences of any stigma or shame affected their recovery overall? Can you provide some examples?
9. How have client experiences of any stigma or shame affected relapse? And how has this affected their help-seeking after a relapse?
10. Have clients talked about experiencing any direct discrimination because of a gambling problem?
11. Anything we have missed about what your clients have said to you about shame/stigma?

**C. Your own professional views:**

1. How do you view the nature and intensity of stigma felt toward problem gamblers? *Prompt – why do you think they are stigmatised by society in this way?*
2. How are client feelings of stigma, shame or low self-esteem incorporated into your approach to treatment?
3. Do you think that stigma affects treatment and recovery for problem gamblers? How? Why? *(May have already covered this in previous client questions)*

4. Is the impact of stigma/shame on treatment different for first time and relapsed problem gamblers who are seeking help? How? Why? (*May have already covered this in previous client questions*)
5. Do you consider that there are some groups of gamblers that are more stigmatised/shamed/ashamed than others? *Prompt for demographics, CALD clients or those with comorbidities*
6. Anything else you would like to say about stigma in your professional view?

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