

Perceived social stigmatisation of gambling disorders and coping with stigma

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Abstract

Aim: This study concerns perceived social stigmatisation of gambling disorder and its determinants, the self-perceptions of people with gambling disorder (self-stigma) and how they cope with stigma. **Design:** In total, 30 interviews with persons with gambling disorder and 60 with professionals were conducted. Selective sampling procedures were employed in the recruitment phase. In the case of professionals, the inclusion criteria were employment in facilities where treatment of gambling disorder is offered, and profession. For people with gambling disorder, the criterion was a diagnosis confirmed by a psychiatrist. **Results:** Elements revealed in past research on stigma-creation processes were reflected in respondents' statements. The type of gambling, the occurrence of negative consequences, the possibility of hiding, personal responsibility, social status and contact with stigmatised populations are perceived determinants of problem gamblers' stigmatisation. Gambling disorder sufferers experience anxiety associated with the possibility of rejection and a fear related to their condition being revealed to others. Various manifestations of cognitive distancing and hiding were coping mechanisms identified in the study. **Conclusions:** People with gambling disorder experience anxiety associated with the possibility of rejection, and they often conceal their disorder, which may hinder their treatment. Therefore the issue of stigma should be addressed in therapy.

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Keywords

coping with stigma, determinants of stigmatisation, gambling, gambling disorder, self-stigma, stigmatisation

People diagnosed with a gambling disorder often have to deal with negative social perceptions (Hing, Holdsworth, Tiyce, & Breen, 2014; Horch & Hodgins, 2008). The fourth edition of the *Diagnostic and statistical manual of mental disorders* (DSM-IV) defines pathological gambling (PG) as persistent and recurrent maladaptive gambling behaviour (American Psychiatric Association, 1994). In the fifth edition of the DSM (DSM-5), pathological gambling was renamed gambling disorder (GD) (Petry, Blanco, Stinchfield, & Volberg, 2013). The disorder was reclassified as “substance-related and addictive disorders” in an effort to clarify the diagnosis, increase its recognition and improve the quality of research related to the disorder (O’Brien, 2011; Petry et al., 2013).

The ways in which people with gambling disorder are perceived affects social reactions towards them. One of the possible responses is social stigmatisation which affects self-perceptions (Tavares, Martins, Zilberman, & el-Guebaly, 2002). The term “stigma”, according to Goffman (1963), refers to an attribute that discredits a person in the eyes of others. Once a person is recognised as having a stigmatised condition, claims are made about other imperfections of the individual on that basis. Most definitions of stigma include two fundamental components: the recognition of difference and devaluation (Dovidio, Major, & Crocker, 2000). Pryor and Reeder (2011) distinguished four manifestations of stigma as public stigma, self-stigma, stigma by association and structural stigma. This article focuses on the first two.

Public stigma

Public stigma is the reaction of society to those with a stigmatising condition which manifests itself in negative attitudes towards the

stigmatised group (Corrigan, 2004; Corrigan & Shapiro, 2010). Public stigma is created through defining people by their condition or problem using judgement and labelling. As a group, people with the same stigmatised condition are assigned a range of negative stereotypes and devalued (Link & Cullen, 1983; Link, Yang, Phelan, & Collins, 2004). Elements that make up the stigmatisation process, according to Corrigan (2000), include stereotyping, prejudice and discrimination. Link et al. (2004) distinguished five distinct elements in the public stigma-creation process: labelling, stereotyping, separating, emotional reactions, status loss and discrimination. Labelling and stereotyping are employed to differentiate a specific group from others and lead to social distancing (Rüsh, Angermeyer, & Corrigan, 2005). Other tools to emphasise difference are emotional reactions to stigmatised individuals such as anger, irritation, anxiety, pity or fear (Link et al., 2004). All these reactions can induce further reactions such as rejection, disapproval, devaluation, discrimination and loss of social acceptance (Corrigan, 1998; Link & Phelan, 2001; Link et al., 2004).

According to a systematic literature review which covered 72 articles and reports, public stigma covers the prejudice and discrimination endorsed by the general population that may affect an individual with gambling disorder (Corrigan, Morris, Michaels, Rafach, & Rüsch, 2012). A number of studies found that people with gambling problems generally attract substantial negative stereotypes, social distancing, emotional reactions, status loss and discrimination (Dhillon, Horch, & Hodgins, 2011; Feldman & Crandall, 2007; Hing, Russell, & Gainsbury, 2016; Horch & Hodgins, 2008, 2013). However, only the study conducted by Hing, Russell, and Gainsbury (2016) covered a population of 2000 adults, while the other

research covered much smaller populations, mostly of students. In the study conducted among Canadian university students ($N = 790$), problem gamblers were often perceived through the prism of stereotypes and considered compulsive, impulsive, desperate, irresponsible, risk-taking, irrational, antisocial, and aggressive (Horch & Hodgins, 2013).

According to Jones et al. (1984), the degree of public stigma depends on several perceived dimensions of the stigmatised attribute or condition, the ease or difficulty of concealing it (concealability), the perceived extent of individual responsibility for the attribute (origin), whether it is possible to return to the previous state over time (course), how destructive it is to interactions with others (disruptiveness), and how much the attribute causes disgust and revulsion (aesthetics) and fear (peril).

Hiding a gambling problem is a very common strategy employed by people with gambling disorder to avoid stigmatisation (Hing, Nuske, & Gainsbury, 2012; Hodgins & el-Guebaly, 2000). However, hiding gambling disorder can cause sufferers to be perceived as odd and thus become even more stigmatised (Feldman & Crandall, 2007). The questionnaire-based Victorian Adult Survey ($N = 2000$) found that the vast majority of respondents (95.2%) stated that problem gambling was at least somewhat noticeable (Hing, Russell, Nuske, & Gainsbury, 2015). According to authors of the Victorian Adult Survey, this finding was surprising in the light of the findings of previous studies in that even the closest family members are often unaware of their partner's or another family member's gambling problem (Hing, Russell, Nuske, & Gainsbury, 2015; Holdsworth, Nuske, Tiyce, & Hing, 2013; Patford, 2009). The issue of how concealability determines the intensity of public gambling stigma still requires diagnosis (Hing, Russell, Nuske, & Gainsbury, 2015).

In relation to the disruptiveness dimension, a substantial majority of respondents in the Victorian Adult Survey considered that problem gambling leads to large disruptions in work or

study (74%), an ability to live independently (63%) and the ability to sustain a serious relationship (79%) (Hing, Russell, Nuske, & Gainsbury, 2015). The disruption caused by problematic gambling to subjects' lives and the lives of their significant others is well documented (Holdsworth et al., 2013), but less is known about the harm on a social level. Thus, further research is needed to better recognise what the significance is of this factor in the severity of stigma (Hing, Russell, Nuske, & Gainsbury, 2015).

Origin is the perceived responsibility of individuals for the stigmatising attribute. Participants ($N = 270$) of Feldman and Crandall's study (2007) read case histories depicting individuals with 40 mental disorders. This study found that "personal responsibility" was one of three factors determining the stigmatisation of mental disorder, including pathological gambling. In a study conducted by Horch and Hodgins (2008), 249 undergraduate university students rated vignettes describing five health conditions on a social distance scale. "Disordered gambling" was more stigmatised than the cancer and control conditions. However, there was no difference in participants' ratings of desired social distance from those with problem gambling, alcohol dependence and schizophrenia, which supports earlier findings that mental health disorders are more stigmatised in comparison to physical illnesses or disabilities (Weiner, Perry, & Magnusson, 1988). A study among students with the use of case histories depicting individuals with mental disorders ($N = 270$) found that "pathological gambling" was rated 13th in terms of the intensity of stigma amongst 40 mental illnesses, slightly less than alcohol dependence (rated 10th) but more than paranoid schizophrenia (20th) (Feldman & Crandall, 2007). These studies were conducted among students and are not representative of larger populations. A questionnaire-based study of 2000 Australian adults found that respondents stigmatised problem gambling more than sub-clinical distress and recreational gambling, but less than

alcohol use disorder and schizophrenia (Hing, Russell, Gainsbury, & Nuske, 2015).

The occurrence of problem gambling is associated with personal negative traits such as lack of self-control, absence of guilt, propensity towards risk-taking, ignorance of gambling odds and unrealistic beliefs about winning (Carroll, Rodgers, Davidson, & Sims, 2013; Hing, Russell, Gainsbury, & Nuske, 2015). Canadian online panel survey research on 4000 adults conducted by Konkoly Thege et al. (2015) showed that, in comparison to substance disorders, behavioural disorders tend to be perceived more in moral terms.

The likelihood of mental disorder stigma is associated with perceived inclinations to aggressive behaviour (Corrigan et al., 2002; Feldman & Crandall, 2007; Horch & Hodgins, 2008). Perceived dangerousness elicits perceivers' fear and avoidance (Bos, Kok, & Dijker, 2001; Feldman & Crandall, 2007). Less than one-quarter (23%) of the Victorian Adult Survey respondents believed that people with gambling problems are likely to be violent towards others, although a larger proportion (42%) believed that they are more likely to do something violent to themselves (Hing, Russell, Nuske, & Gainsbury, 2015). People with gambling disorder are not perceived by most respondents as dangerous, but those who judge them as being very dangerous set greater social distance (Dhillon et al., 2011).

Public stigma depends on whether the condition is viewed as reversible or not, with irreversible conditions tending to be more stigmatised (Jones et al., 1984). Recovery is quite common among people with gambling problems (Abbott, Williams, & Volberg, 2004; Slutske, Blaszczynski, & Martin, 2009), so people who do not recover from addiction may be judged more severely.

Another condition which can influence stigma is contact with the stigmatised population. Some studies confirmed that increased contact matters (Corrigan et al., 2012; Dhillon et al., 2011), while another found no relationship (Horch & Hodgins, 2008).

Perceived stigma is considered as the awareness of public stigma, or a belief that others have passed judgement and hold stigmatising thoughts or stereotypes about a condition (Barney, Griffiths, Jorm, & Christensen, 2006). Most people with gambling problems included in a survey conducted in Australia ($N = 203$) agreed the general public thinks that problem gambling is the person's own fault. Regarding the process of stigma creation, most respondents stated that, according to the general public's opinion, problem gamblers are addicts. Others may consider them to be irresponsible and would feel anger towards problem gamblers and look down on them (Hing, Russell, Nuske, & Gainsbury, 2015). In-depth interviews with 44 people with recent experience of gambling problems found that many participants expressed a belief that people without gambling problems considered those with gambling problems in a highly negative light. More than half had felt judged by others because of their gambling. A few participants were able to describe actual experiences, but most could only talk about a general feeling of fear of being judged (Hing, Nuske, Gainsbury, & Russell, 2015).

Self-stigma

Self-stigmatisation has been defined as the process in which a person with stigmatised condition becomes aware of public stigma, agrees with those stereotypes, and internalises them by applying them to him or herself (Corrigan, Larson, & Kuwabara, 2010). The condition involves an anxiety of being exposed to stigmatisation and the potential internalisation of negative beliefs and feelings associated with the stigmatised condition (Hing, Nuske, Gainsbury, Russell, & Breen, 2016; Hing & Russell, 2017a; Pryor & Reeder, 2011). Self-stigmatising beliefs diminish self-esteem, self-efficacy and self-perception of social worth (Corrigan, 2004; Hing & Russell, 2017a, 2017b; Horch & Hodgins, 2015; Watson, Corrigan, Larson & Sells, 2007). People with gambling disorder depicted

themselves using pejorative terms such as “embarrassed”, “weak”, “stupid”, “guilty”, “disappointed” or “remorseful” (Carroll et al., 2013; Hing, Nuske, et al., 2015).

Coping strategies

Stigmatised people have a vast array of responses to stressors resulting from their devalued social status including emotional, cognitive and behavioural responses (Holohan, Moos, & Schaefer, 1996; Miller & Kaiser, 2002). People usually have several responses to stigma, and feedback from one response may alter the next response while several strategies can be used simultaneously (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). Link et al. (2004) described five coping mechanisms to manage stigma: hiding the problematic condition, avoiding social interactions and support, educating others about the condition, challenging prejudice and discrimination, and cognitive distancing from the stigmatised group.

Hiding was the main mechanism used by people with gambling disorder to cope with stigma (Carroll et al., 2013; Hing, Nuske, et al., 2015; Horch & Hodgins, 2015; Link et al., 2004). The Survey of People with Gambling Problems ($N = 177$) showed that hiding was grounded in fear of rejection, fear of shame, fear of being labelled “a problem gambler” and of being stereotyped, judged, demeaned and discriminated against. The other coping mechanisms including withdrawal, cognitive distancing, educating and challenging were less widespread (Hing, Russell, Nuske, & Gainsbury, 2015).

Although shame and fear about stigma are barriers to treatment very commonly identified in the studies (Dąbrowska, Moskalewicz, & Wieczorek, 2017; Evans & Delfabbro, 2005; Gainsbury, Hing, & Suhonen, 2014; Hing, Nuske, et al., 2016; Hodgins & el-Guebaly, 2000; Suurvali, Cordingley, Hodgins, & Cunningham, 2009), there is a shortage of studies focusing specifically on problem gambling

stigma in Europe. Dimensions of stigma such as disruptiveness require further exploration (Hing, Russell, Nuske, & Gainsbury, 2015), because so far only harm to individuals was considered. The results of studies on *concealability* are contradictory (Hing, Russell, Nuske, & Gainsbury, 2015), so this topic also requires further exploration. A lot of studies focus on public reactions to mental disorders (Hing, Russell, Gainsbury, & Nuske, 2015; Horch & Hodgins, 2008; Salonen, 2014) but little attention has so far been brought to the personal experiences of stigma by people with gambling disorder and their perception of social stigmatisation. Most previous studies on gambling disorder stigma employed quantitative design and specific case vignettes. In addition, most of the research has been carried out in Australia and the meaning, practice and outcome of stigma depends to a large extent on culture (Yang et al., 2007).

The study focuses on subjective experience or respondents’ opinions on perceived stigma and does not necessarily reflect social stigma as a phenomenon. Perceived stigma as mentioned above can be defined as a belief that others hold stigmatising thoughts or stereotypes guiding their behaviour.

This article aimed to examine:

- perceived social stigmatisation of people with gambling disorder;
- perceived determinants of public stigma of people with gambling disorder;
- how people with gambling disorder perceive themselves;
- what coping strategies are employed to manage stigma.

Methodology

A qualitative approach was employed in this study. As Miles and Huberman (2000) have underlined, qualitative data is attractive because it provides a source of well-established, rich descriptions and explanations

of processes in clearly defined specific contexts. These allow observations of passages of time, cause and effect relationships as well as delivering useful explanations.

The sample

Within the framework of the study, individual, semi-structured interviews with people with gambling disorder, social workers, therapists employed in addiction treatment facilities, general practitioners and psychiatrists were conducted in the first half of 2015 in Warsaw. Finally, 90 interviews were conducted: 30 interviews with persons with gambling disorder and 15 interviews within each of the four groups of professionals.

The study was anonymous and respondents' opinions were denoted only by code. All respondents were informed about the aim of the study and signed a consent form for participation. All interviews were recorded and then transcribed.

Purposive sampling procedures were employed with the aim of gaining complete and comprehensive information from the research question perspective. When it came to the professionals, employment status in the gambling treatment facilities, along with their profession, determined their participation. The inclusion criteria for people with gambling disorder were primarily diagnosis of gambling disorder confirmed by a psychiatrist. In Poland, diagnosis is based on ICD-10 diagnostic criteria. The term *pathological gambling* is used in medical records and a diagnosis is necessary to obtain treatment within the national healthcare system. In the article, the authors use the term *gambling disorder*, because in their opinion it is a more accurate term. The diagnosis was not verified in any way, and the respondent's declaration was accepted as proof that their problem had been diagnosed. Only those who declared they had a psychiatric diagnosis were included in the study.

Professionals were enrolled for the project in their place of employment. Patients were

enrolled in alcohol and drug outpatient treatment facilities and during Gambling Anonymous (GA) meetings. In the outpatient units, people with gambling disorder were recruited by therapists and then researchers contacted patients who agreed to participation in order to conduct an interview. At the GA meetings, information about the study was delivered by the leader of the group and those who were interested in participating were contacted directly by interviewers.

Sample characteristics

The vast majority of people with gambling disorder were males and the study included only three females. The average age was 38 years, with a range of 25 to 63 years. More than half (60%, $n = 18$) of the respondents had a university degree (bachelor's or master's degree). There were no participants with primary and lower secondary education, and only 10% ($n = 3$) had a vocational education. The remaining 30% had secondary education. About 70% ($n = 20$) of the respondents worked on a fixed employment contract, almost a quarter ($n = 7$) had their own business and the rest were retired. Only one person was unemployed. The group of respondents was dominated by slot-machines players and regular casino visitors. About 30% ($n = 13$) of respondents used the internet for gambling and the same percentage played cards in alternative locations to casinos without use of the internet.

In contrast to the group with gambling disorder, the professionals were mainly females (70%, $n = 42$). Their average age was 43 and varied depending on the professional group with the youngest being therapists and the oldest psychiatrists (ages ranging from 25 to 72 years). A clear majority lived in Warsaw.

Guidelines for qualitative interviews

Interviews with people with gambling disorder covered the following stigma-related issues:

perceptions of people with gambling disorder by others, social reactions towards people with gambling disorder, self-perceptions of people with gambling disorder and how they deal with social reactions. The guideline for professionals included the same topics. All the interviews contained a rubric allowing the collection of basic socio-demographic data such as age, gender, place of residence, marital status, education and employment. The interviews lasted between 40 minutes and an hour and a half.

Data analysis

A thematic-analysis approach was employed (Guest, MacQueen, & Namey, 2012) to analyse data. The analysis was initiated by reading the full texts and making notes on ideas for codes emerging from the research material. The next step was to examine the codes and data to identify significant broader patterns of meaning (potential themes). An analysis was conducted by two independent researchers, which helped to ensure that none of the categories would be skipped and data was similarly interpreted. A common analysis framework was created by discussing doubts and problems. The last phase involved developing a detailed analysis of each theme and examining its scope and focus.

Ethical approval

Ethical approval for the study was obtained from the Bioethical Commission of the Institute of Psychiatry and Neurology, Warsaw, Poland (ref. 24/2015).

Results

Perceived social stigmatisation of people with gambling disorder

Labelling and stereotyping in the eyes of respondents. People with gambling disorder could, in their own opinion, avoid stigma as long as their problem was not obvious to others and they were not labelled by diagnosis or by having their

problem named by loved ones, neighbours or friends.

As long as no one knows about it, there is no reaction. But when it comes to light, it is not treated positively. Because every addiction is understood as a sort of limitation. (PG3103M1)

People with gambling disorder perceived that they were perceived by others through the prism of stereotypes. Once someone is recognised as a gambler, they are assigned attributes common to all gamblers.

Therapy helps me to accept an addiction as a disease. Not in moral terms, that it is something bad, just because we are judged that way by relatives. As an idiot, a loser moron or a bad man who lies and extorts money . . . (PG3003M1)

Gamblers are perceived as good-for-nothing. Gambling tends to be associated with immaturity and recklessness. (PG1004M3)

People with gambling disorder expressed the view others perceive them as bad people and through the prism of their addiction. In their opinion, labelling an individual as a “problem gambler” entails a number of assumptions about their personality.

Generally, a person of this kind is certainly not a good man in the opinion of others. Generally speaking, this is evil and people call this evil. (H2804M1)

One of the therapists stressed that women in particular may have concerns about revealing a gambling problem as they usually face greater condemnation and stigmatisation of addiction than men.

A woman certainly feels more shame about starting treatment than men do. For women, there is an even greater fear of social stigma, just like with alcoholics. When a man is drunk, people smile at most, but once a woman drunk, people are not so liberal. (T2703M2)

Separation through social distancing as perceived by respondents. Respondents reported cases of other people's hostility in relation to their gambling disorder. One of the respondents described when his girlfriend's parents put pressure on her to end their relationship even though he had been taking steps to address his problems.

My partner's parents wanted us to part, and because of their pressure, that's what happened. My girlfriend left me when I was already on the right path. It had already started to get better at work and at home. (PG2204M1)

Respondents noticed that potential partners may have concerns about dating a person with gambling disorder as they fear their partner's relapse into addiction.

If I enter into a deeper relationship, my partner may be a bit afraid. It is my experience they were afraid of what would happen if I returned to addiction. (PG0605M1)

The disclosure of problems with gambling may end with unemployment as in the case of another respondent.

When my co-workers learned that I gambled, my boss immediately said that I'm fired. (PG0906M1)

Others' emotional reactions as perceived by respondents. In the opinions of respondents, information that someone is a gambler may attract interest and curiosity about the various aspects of gambling, but also anxiety in terms of the extent of damage that it can cause.

If a friend of mine learned that I was a gambler, it aroused interest in how it happened, why and how much money I had lost. So there was interest but when I said how long I'd been doing it, I often saw dismay and fear in my friends' faces. (PG0806M1)

According to respondents, gambling disorder evokes disgust and reluctance among other emotions. However, these feelings are related not to gambling itself, but to behaviours such as cheating or theft from close family members and friends.

It's just that certain behaviours I have indulged in are very unacceptable and arouse hostility or even repugnance in some. (PG3003M2)

However, respondents reported also positive or neutral reactions when someone reveals a gambling disorder. Some people appreciate the trust and honesty they have received.

I was hiding my problem, but in one case I told the boss, and it was met with amusement rather than stigma. (PG003M1)

People react positively or indifferently. For some people, it may not be worth talking about, but I also received words of support or thanks for my honesty because for many it was important. (PG1704M1)

Status loss and discrimination as perceived by respondents. Respondents noted the distance and mistrust displayed towards people with gambling problems in the form of a reluctance to lend them money, limited trust and a perception of the relationship as a source of potential problems. Respondents quite often mentioned the loss of trust both among loved ones and others.

People are reluctant to lend us money, some people treat the gambler as a leper from whom it is better to stay away. (PG1505M4)

I think it is not important whether it is a gambler, an alcoholic or drug addict. A man who has problems with himself can be negatively perceived or at least lose their employer's confidence. (PG0106M1)

I have the impression that there is a loss of trust. There was a moment in 2008 that my girlfriend told me to return the keys to the apartment. It is now 2015 and I still do not have those keys. (PG3003M1)

According to respondents, social reactions can be particularly strong especially immediately after disclosure. Over time, people get used to someone being a “gambler” and their reactions become more moderate. By getting to know this person better, they can get rid of some of their prejudices.

... However, I feel that talking about it would be a hindrance in interpersonal contacts and in finding a job. I live in a tenement house, there are eight apartments and everyone knows that I have a problem so they treated me just like some madman, an outcast. I met with, I do not know, maybe a bit of rejection, as if people were afraid of me. Now, I think they're used to it – they see that I'm not so dangerous. (PG3003M1)

Perceived determinants of social perceptions of people with gambling disorder

Type of gambling. Respondents believed that some forms of gambling can be culturally based, socially acceptable and free from heavier negative connotations. According to some respondents, people playing lottery games will experience less stigmatisation than those playing on slot machines or poker players.

Playing the lottery is common, it is not met with negative reactions. Those who play slot machines are already treated differently. People who play poker on the net or other games... I think it is met with mistrust and misunderstanding, because people have doubts about how to define it. Behaviour like this undermines public trust in someone who wants to earn or relax like this. (T1802F1)

Some forms of gambling, according to respondents, are less stigmatised because they are not linked with the possibility of developing disorder.

Another example is the stock market. In this case, the harm is not so clear and spectacular. This is accompanied by a whole bunch of different false

beliefs. Failures and problems are seen as the essence of the stock exchange, that some people win and others lose but this has no connection with the player's addictive behaviour. (PS2804M1)

An example of this is sports betting, which is not considered to be gambling, only as something comparable to accepted stimulants like coffee. (PS2804M1)

Occurrence of negative consequences. According to professionals, people with gambling disorder are often not perceived negatively, even if they gamble intensively for many years, as long as the consequences are not too harmful or may be effectively concealed. In their opinion, the negative reactions start to appear when the first consequences gambling are noticeable in the form of neglect of duties or falling behind with loan instalments. Usually, it is the family that reacts first by exerting pressure on the gambler to start treatment.

Stigmatisation by the family can be quite strong, because the family is also a victim and feels the most negative effects of this disease. They already know what gambling is. (T2703M1)

When a player begins to take on debts and deprives the family of income, then the family begins to exert pressure, set conditions and begins to perceive this behaviour as a problem. (PS2805M1)

One of the professionals noted that the reaction starts when someone loses all their money, severely depletes the family's budget or spends a certain proportion of their income on gambling.

If someone gets a salary, and goes about losing it all, it may be concluded that he is addicted; these people spend most of the day gambling or thinking about it.

Moderator: Do you think that lotteries can lead to addiction?

I think it is a fine line. If someone spends most of their salary, I think that even playing the lotto can be defined as gambling. (GP1902F1)

Professionals stressed that the more positive image of people with gambling disorder, in comparison to people with substance use disorders, stems from the negative consequences of gambling being, according to common sense, not of as much concern to society as a whole while only directly affecting the people with gambling disorder or their families. Otherwise, these consequences are not such a serious nuisance to society, as in the case of other addictions.

Gambling is socially treated differently to alcohol dependence because in social opinion no one is much affected by it. (SW1203F2)

It seems that people with gambling disorder do not harm anyone because they stay on the gambling premises. It is not visible, it is not spectacular like when someone gets drunk and causes lots of visible trouble. Or when driving drunk or under the influence of drugs causes an accident. (T1903F1)

Possibility of hiding. One of the psychiatrists emphasised that the negative consequences of gambling are not visible at first contact “to the naked eye”. In the case of people addicted to substances, the signs of physical and mental destruction are clearly visible. People with gambling disorder generally do not differ from others in terms of appearance or behaviour.

It seems to me that society is more critical of a person addicted to alcohol than to gambling. The strength of rejection or humiliation is less in the second case. It can be because the neighbourhood does not visibly see the harm of gambling, and there are no mental changes because it is not associated with intoxication. (PS2304F1)

Personal responsibility. As respondents pointed out, it is a common perception that a gambling disorder is related to personal weakness and propensity to hedonism. In the case of gambling disorder, a strong will and motivation to change

should be enough to get rid of the “unpleasant habit”. In this sense, people with gambling disorder are judged more negatively than people with substance use disorder.

I think that people with a gambling addiction can be perceived differently. Alcohol dependence is regarded by society as a disease, whilst gambling disorder is treated as an annoying habit. Probably it is seen as a less acute addiction that can be dealt with at any time. The inability to control gambling stems from a propensity for hedonism and a weak will and not from any disease. So in summing up, those addicted to gambling are perceived as worse compared to other types of addiction. (SW1201F1)

Well, people are different – some look at it from a positive point of view, others maybe think that this is not a disease? It is a whim and a man should deal with it himself. Taxpayers should not pay for it. (PG2703M1)

According to one of the professionals, this kind of definition of the problem can also be shared by professionals and can lead to the reluctance to treat people with gambling disorder.

I think that even among professionals like psychiatrists or psychologists, there is a clear tendency to perceive a behavioural disorder in this way [moral – authors]. Gambling disorders are typically seen as a personal weakness. Although there may be a reluctance to admit it, these people are seen, it seems to me, as flawed. Medical personnel may be reluctant to deal with the problem, which is perceived as personal, hence the tendency to neglect the problem. (PS1002M1)

Social status. People with gambling disorder were, in the opinion of the professionals of this study, were generally perceived more positively than those with substance abuse disorders, as these disorders are usually associated with the socially excluded and the impoverished who are often regarded as repulsive. According to

professionals, a commonly held opinion is that people with gambling disorder are better educated, situated higher in the social structure and are generally wealthy. For that reason the social assessment of gambling disorder is more favourable.

I think that gamblers are perceived differently from those addicted to substances. The gambler is often perceived as a wealthy, intelligent man. According to social perceptions, people with alcohol abuse disorder are people from the lower social strata, with a lower intelligence level. (SW2804F1)

I think that the social perception of the gambler is more positive. A gambler is someone who can afford to lose money. Someone who has money is better perceived than someone who asks for money on the street for a drink. (T2603F1)

Contact with the stigmatised population. In the opinion of the interviewed persons with gambling disorders, they are assessed and treated differently by people who are familiar with the problem of gambling disorder in comparison to those who have never faced the problem. People who know the problem are more willing to show understanding and support.

Persons familiar with this problem, having someone in the family or a close friend who has become involved in the problem of addiction, will perceive gamblers differently than people who have no knowledge about it. People who do not have knowledge are either indifferent or are rather hostile. On the other hand, people who are familiar rather tend to be supportive and sometimes ask how it is going. (PG1504M1)

The self-perception of people with gambling disorder

The persons with gambling disorder often agreed with the negative perception of

themselves as people who cannot be trusted. Moreover, they expressed understanding for these opinions.

People do not trust us [people with gambling disorder – authors], which is understandable. I also cannot trust myself. No matter how long I go without gambling, I can never promise that I will not do so for the rest of my life. Recently my wife's friend borrowed some money from her. "Give this money back to her", she stressed, to ensure that the money should be returned to my wife. As if she was warning me not to go to the casino. So it's that kind of thing. (PG1504M2)

Even when I borrowed money, I did not give it back. So people treated me the way I deserved. Friends were not keen on being around me and did not trust me. (PG0605M1)

They are aware that they cannot be positively judged by others, so they experience anxiety associated with the possibility of rejection and fear related to the possibility or necessity of revealing their disease to a potential partner or employer. They are afraid that revealing their problems when making first acquaintances can discredit them and undermine their efforts to establish a relationship or to get the job.

I hide my addiction. Maybe this is more my fear that I will meet with rejection. I met a woman who I like and I have a dilemma whether to tell her or not. I'll tell her, but I do not know when to tell her – right away, or next week or in a month. Well, I decided to live honestly and that she could decide whether she wanted to be with someone like me. (PG3003M1)

People with gambling disorder feel shame about their problem; they have a feeling of being someone worse, someone who did not manage in life, a stupid person. Social reactions undermine their self-esteem.

I am ashamed of my illness, I don't talk about my problems. I think that if someone has not coped in life, he is worse in some way. Society thinks that

if someone is sick, is a worse person. And I do not want to be worse, I want to be normal. And treated normally. (PG3103M1)

At the meetings for AG, I learned that it is an addiction, not some kind of . . . Before, I believed something was wrong with me, that I was stupid. (PG1504M1)

Coping strategies used by people with gambling disorder to manage stigma

Hiding. As shown by the gambling disorder subjects' statements, they hide their problematic condition as they are afraid of rejection. Sometimes they decide to reveal the stigmatised condition to someone they trust.

After treatment I worked full time, but as I say, I was hiding the disease. But in one case, I told the boss about my problem and it was just met with amusement rather than being stigmatised. (PG3003M1)

Most people hide gambling disorder, but revealing it can be a relief. However, often the respondents do not make the decision and wait for it to happen.

I am counting on the discretion of those who know my problem, although revealing the problem is often a relief. (PG2603M1)

Cognitive distancing. Therapists also highlighted other forms of coping mechanism for dealing with stigma. They pointed out that people with gambling disorder who participate in therapy do not want to be identified with people with substance abuse disorders, distancing themselves from their behaviour and lifestyle. People with gambling disorder describe their habit as a "better addiction" that does not cause as much social exclusion as substance use disorders. They believe that these addictions are not equal. They assess the lifestyle of people with substance use disorders as very risky.

Sometimes I think that people addicted to gambling perceive themselves as better than those with an addiction to alcohol or drugs. They believe that their addiction is "better", less threatening. They're probably just feeling slightly better in comparison to those people who drink heavily or take drugs. Maybe this is some kind of defence so as to not to feel "sucked in". This group of addicts is characteristic because they think "we're better because we do not drink and nobody will find us in a ditch". (T1902F1)

Professionals pointed out that people playing poker argue that it requires an extraordinary intelligence and unusual abilities. Conversely, playing slot machines can be seen as a mindless form of entertainment.

They believe that some forms of gambling require skills of the mind and intelligence. Poker players stand out in this group. They argue that this is a unique game, and they are the elite. In contrast, playing slot machines is a rather mindless game. It is just a way of relieving stress. (T1902F1)

Discussion

It should be emphasised that the opinions cited above are respondents' subjective opinions reflecting their perception and interpretation of social behaviours and events. Someone may argue that, for example, not lending money to people who have problems with gambling is behaviour based on rational premises, not a manifestation of stigmatisation. In turn, this behaviour can be interpreted by a person with a gambling disorder as a form of stigmatisation, especially if the person had undergone treatment. That is why this article uses the term *perceived stigmatisation*. However, it is worth mentioning that the respondents' statements match quite well the theoretical categories highlighted on the basis of known stigma theories, and find confirmation in the results of other related studies.

Perceived stigmatisation of people with gambling disorder and its dimensions

All elements constituting the stigma-creation process (Link et al., 2004) were reflected in respondents' statements. According to these, people with gambling disorder can avoid stigma as long as their problem is not obvious to others and they will not be labelled. Once labelled, the stereotypes regarding the social group to which an individual is perceived to belong are applied. A person with a gambling disorder, according to respondents of the current study, may be perceived as an "idiot", an immature and reckless individual, as someone who wants to easily earn some extra money or have too much money, someone who is a liar and characterised by their weak willpower. This finding confirmed the negative and stereotypical social image of people with gambling disorder reported in other studies (Carroll et al., 2013; Hing, Nuske, et al., 2015; Hing, Russell, Gainsbury, & Nuske, 2015; Horch & Hodgins, 2013).

Respondents of the discussed study recognised that other people maintain social distance towards people with gambling disorder. This manifests itself in reluctance to enter into relationships or employ them. Hing, Russell, and Gainsbury (2016) found that the willingness to socialise with a person with problem gambling decreased as the closeness of the relationship increased. As revealed in other studies, people with gambling disorder often experience social rejection and social distancing (Carroll et al., 2013; Dhillon et al., 2011; Feldman & Crandall, 2007; Hing, Nuske, et al., 2015; Horch & Hodgins, 2008).

The process of stigma creation includes emotional reactions toward stigmatised individuals such as anger, irritation, anxiety, pity or fear (Link et al., 2004). Respondents in the study by Hing, Russell, Nuske, and Gainsbury (2015) stated that the general public would feel anger towards, and would look down upon, problem gamblers. According to respondents of the discussed study, information that

someone is a gambler may arouse interest and curiosity about the various aspects of gambling, but also anxiety, disgust and aversion about the damage that it can cause. However, this study shows that, over time, people can get used to the information that someone is a "gambler" and their reactions can weaken.

All these reactions can induce behavioural consequences such as rejection, disapproval, devaluation and discrimination in interpersonal interactions and loss of social acceptance (Corrigan, 1998; Hing, Russell, Nuske, & Gainsbury, 2015; Link & Phelan, 2001; Link et al., 2004). The discussed study respondents noted the distance and mistrust towards people with gambling problems. This included a reluctance to lend them money, limited trust and a perception of relationships as a source of potential problems. Their statements are based, to a large extent, on their interpretation of situations they have experienced.

Dimensions such as the occurrence of negative consequences (disruptiveness), the possibility of hiding (concealability), personal responsibility (origin) are the same as those distinguished by Jones et al. (1984). Three more dimensions were identified in the current study as the type of gambling, contact with stigmatised group and social status. In turn, the study did not identify such factors as "course" and "peril".

According to respondents of the current study, some forms of gambling, for example playing lotteries, are not associated in the social consciousness with the possibility of development of a disorder. This form of gambling is common, socially acceptable and not burdened with negative connotations. People who engage in this form of gambling are judged less severely and are less stigmatised. As shown by Hing and Russell (2017b), those whose most problematic form of gambling was horse-race betting tended to have lower stigma than others. It seems that some forms of gambling are not stigmatised as strongly as others. Probably, the perception of different forms of gambling and stigma towards them can differ with society.

Even in regions like Europe, largely homogeneous levels of recognition and prejudice show significant variation in public responses to mental illness (Olafsdottir & Pescosolido, 2011).

It appears that people with gambling disorder do not experience stigma as long as it does not cause too many negative consequences for the player, their family and society as a whole. Holdsworth et al. (2013) found that the *disruption* to the lives of people with gambling disorder and to their families contributes to its public stigmatisation. While in the Victorian Adult Survey, the damage caused by problem gambling was described at the individual level (Hing, Russell, Nuske, & Gainsbury, 2015), this study's respondents rather considered that on the social level. According to them, gambling disorder is not perceived as particularly burdensome for the public. Alcohol or drug dependent people can cause car accidents and act aggressively or noisily in public places. These problems are not attributed to gamblers.

Jones et al. (1984) highlighted a factor, which he called *concealability* (possibility of hiding). This refers to keeping a gambling problem hidden, something that is common because of a sense of shame and the fear of stigmatisation (Hing et al., 2012; Hodgins & el-Guebaly, 2000). As the current study shows, gambling behaviours are relatively easy to hide in comparison to substance abuse disorders because of a lack of any external signs that indicate a problem.

"Personal responsibility" attributed to behaviour determines stigmatisation responses (Feldman & Crandall, 2007). Jones et al. (1984), amongst other dimensions influencing social perception of problems, highlighted *origin* – the perceived extent of personal responsibility for such an attribute. As this study has shown, people with gambling disorder may meet with greater condemnation than those with substance use disorders because their problems are seen in moral terms as arising

from a weakness of character. The responsibility for solving the problem is on their side. This finding is consistent with previous studies (Dhillon et al., 2011; Hing, Russell, Gainsbury, & Nuske, 2015; Horch & Hodgins, 2008; Konkolý Thege et al., 2015).

Social status is a factor which influences how people are perceived by society (Penner & Superstein, 2008). Social characteristics and characteristics of the stigmatised condition are combined and shape the evaluation of a person's behaviour as well as the probability of identifying that person as mentally ill (Pescosolido, Martin, Lang, & Olafsdottir, 2008). According to this study, people with gambling disorder can be less stigmatised than people with substance abuse disorder, as their social status is judged to be higher. Koenig (2009) argued that less stigma is applied to wealthy people who engage in excessive gambling as they are better able to sustain their losses.

This study confirmed that contact with people with gambling disorder can weaken stigma, which is consistent with the results study of the Dhillon et al. (2011) and Goffman's theory (1963) according to which the *wise* (representatives of the *normals* who are familiar with the details of the life of individuals with stigma) are more friendly towards people with gambling disorder than others.

This study did not confirm that people with gambling disorder can be seen as aggressive or impulsive (Corrigan et al., 2002; Horch & Hodgins, 2008). This may be related to differences in methodology, as in this study respondents were patients and professionals, while other studies were conducted among the general population or in special segments of society for example among students.

Self-perceptions of people with gambling disorder

Numerous studies have shown that stigma has harmful consequences for the mental condition of stigmatised individuals and affects self-perceptions and self-esteem (Dinos, Scott,

Serfaty, Weich, & King, 2004; Hing, Russell, Gainsbury, & Nuske, 2015; Meyer, 2003; Stutterheim et al., 2009). People with gambling disorder included in this study feel shame about their problem, have a feeling of being someone worse, someone who did not manage in life and a stupid person. Internalisation of stigma leads to a deterioration of their self-esteem and self-efficacy in relation to resolving their problem. This was confirmed by other studies showing that self-stigmatising beliefs are devastating for self-esteem, self-efficacy and self-perception of social worth of people with gambling disorder (Corrigan, 2004; Hing, Nuske, et al., 2015; Hing & Russell, 2017a, 2017b; Watson et al., 2007).

The current study demonstrated that people with gambling disorder experience anxiety associated with the possibility of rejection, a fear related to the possibility or the necessity of revealing their condition. In another qualitative study, participants raised serious concerns about being perceived as “a problem gambler”, as this label would attract degrading stereotypes, social rejection, hostile responses and prejudicial behaviours (Hing, Russell, Gainsbury, & Nuske, 2015). Concerns about disclosure emerged as a major theme in the study of Dinos et al. (2004). The participants’ attempts to avoid disclosure resulted in stress, isolation and a sense of shame.

The coping strategies used by people with gambling disorder to manage stigma

Stigmatised individuals may try to reduce the negative consequences of possessing stigmatising attributes by employing a variety of coping strategies. As this study has shown, people with gambling disorder are afraid of rejection and conceal the problematic condition, which is the most common mechanism revealed in other studies (Carroll et al., 2013; Hing, Nuske, et al., 2015; Horch & Hodgins, 2015; Link et al., 2004). Sometimes they employ a “selective disclosure” strategy (Goffman,

1976) and they disclose their stigmatised condition to only a selected few.

Other studies have revealed cognitive distancing from other people who have gambling problems (Carroll et al., 2013; Istrate, 2011; Radburn & Horsley, 2011). This study established that people with gambling disorder distance themselves from the behaviour and lifestyle of people with substance abuse disorders. This can be defined as cognitive distancing not just from one’s own group but from another, even more stigmatised group.

Another form of cognitive distancing is the demonstration that some forms of gambling require extraordinary intellectual ability, which enables the avoidance of identification with other group members. The same coping strategy was presented by Radburn and Horsley (2011).

Limitations

The study has a number of limitations. In the study only those who already had experiences with gambling treatment participated, so the perspective of people who are outside the care system was not included. The study’s qualitative design does not ensure the representative nature of the data. Qualitative data is more easily influenced by the researcher’s personal biases.

The study assessed perceived stigmatisation and therefore reflects the beliefs and feelings of respondents and their interpretation of others’ behaviour. Their perception does not necessarily have to find its source in experienced acts of stigmatisation. These can be based on anticipated reactions alone or on their own interpretations of social facts.

In the current study, the statements of people with gambling disorder and professionals who work with them were taken into consideration. People with gambling disorder may be ashamed of talking about some forms of discrimination, sometimes remain unaware of these things and perceive them as deserving of disdain or belittling. On the other hand, they can exaggerate social reactions and all unfavourable or unpleasant reactions of others and interpret these as a

form of stigmatisation. Professionals, by virtue of their training, may be more aware of the different aspects of stigmatisation processes and have a more objective overview of the situation. On the other hand, it could be rather unrealistic to have expectations that they will frankly talk about their own prejudices or stereotypical perceptions of people with gambling disorder. Both professionals and people with gambling disorder may feel obliged to talk about some manifestations of stigmatisation to meet the researcher's expectations.

Conclusions

People with gambling disorder, in their own opinion and according to professionals, are perceived very often by society from a moral perspective. They experience anxiety associated with the possibility of rejection and they often conceal their disorder. Their fears do not necessarily have to find their source in acts of stigmatisation. These can be related to guilt and low self-esteem. However, the fear of stigma prevents or hinders treatment, so the issue of stigma should be addressed during therapy.


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